WIC Nutrition/Health Assessment

Child

Date _____

(Health Goal: Grow and develop in a nurturing home and begin to make dietary and lifestyle habits for a lifetime of good health.)

Child's name _____ **Child's date of birth** _____

1. **Complete this question if this child is less than 2 years of age. If not, go to Question 2.**
   How much did this child weigh at birth?
   _____ Pounds _____ Ounces
   What was this child's length at birth? _____ Inches
   Was this child born early? ☐ Yes ☐ No
   If yes, how many weeks early? _____
2. Which of these meals/snacks does this child usually eat?
   ☐ Breakfast ☐ Morning snack
   ☐ Lunch ☐ Afternoon snack
   ☐ Dinner/supper ☐ Evening snack
3. How would you describe this child's appetite?
   ☐ Good ☐ Fair ☐ Poor
4. Does this child feed her/himself?
   ☐ Always ☐ Sometimes ☐ Never
5. How would you describe mealtimes with this child?
   ☐ Always pleasant ☐ Never pleasant
   ☐ Usually pleasant ☐ Seldom eats with child
   ☐ Sometimes pleasant
6. How many days does your family eat together each week?
   ☐ Never ☐ 1–3 days ☐ 4–7 days
7. Does your family watch TV during family mealtime?
   ☐ Always ☐ Sometimes ☐ Never
8. Does this child eat or take a meal from a fast-food restaurant 2 or more times per week?
   ☐ Yes ☐ No
9. Is there a working stove, oven, and refrigerator where this child lives?
   ☐ Yes ☐ No
10. Were there any days last month when your family didn't have enough food to eat or enough money to buy food?
    ☐ Yes ☐ No
11. Are you concerned about this child's weight?
    ☐ Yes ☐ No
12. Is this child a vegetarian?
    ☐ Yes ☐ No
13. Is this child lactose intolerant?
    ☐ Yes ☐ No
14. How much juice does this child drink daily?
    ☐ Less than 4 ounces ☐ 9–12 ounces
    ☐ 4–8 ounces ☐ Greater than 12 ounces
15. Is this child often constipated or have problems with bowel movements?
    ☐ Yes ☐ No
16. How many glasses of water does this child drink on a typical day?
    ☐ None ☐ 4–7
    ☐ 1–3 ☐ 8 or more
    Does this child's water supply contain fluoride?
    ☐ Yes ☐ No ☐ Unknown
17. Does this child take a vitamin/mineral/herbal supplement?
    ☐ Yes ☐ No
    Does the supplement contain Vitamin D?
    ☐ Yes ☐ No
18. Does this child eat or crave non-food items like clay, laundry starch, paint chips, paper, dirt, or ice?
    ☐ Yes ☐ No
19. Does this child use a bottle?
    ☐ Yes ☐ No
20. Does this child take a bottle to bed at night or carry a bottle or training cup around during the day?
    ☐ Yes ☐ No
21. Does this child take a pacifier dipped in honey, syrup, or sugar?
    ☐ Yes ☐ No
22. When does this child visit a doctor or clinic?
    ☐ At regular check-ups
    ☐ Just when sick
    ☐ Never
23. Does this child receive regular dental care (visit a dentist)?
    ☐ Yes ☐ No
24. Is this child currently in foster care?
    ☐ Yes ☐ No
    If yes, has the child changed foster homes in the last 6 months?
    ☐ Yes ☐ No
25. Does this child eat any of the following:
    ☐ Raw or undercooked meat, fish, poultry, or eggs
    ☐ Unpasteurized milk/soft cheeses
    ☐ Unheated lunch meats, hot dogs, or other processed meats
    ☐ Raw vegetable sprouts
    ☐ Unpasteurized juice
    ☐ None
26. Does this child eat any of these foods? (*Check all that apply*.)
    ☐ Round or hard candy ☐ Nuts and seeds
    ☐ Pretzels and chips ☐ Popcorn
    ☐ Raw carrots or celery ☐ Whole grapes
    ☐ Peanut butter ☐ Hot dogs
    ☐ Marshmallows

Child's name _____ **Child's date of birth** _____

27. Which of these foods/beverages does this child normally eat or drink?

Grains

- ☐ Bread
- ☐ Rolls
- ☐ Bagels
- ☐ Muffins
- ☐ Popcorn
- ☐ Noodles/pasta/rice
- ☐ Tortillas
- ☐ Crackers
- ☐ Cereal/grits

Vegetables

- ☐ Corn
- ☐ Peas
- ☐ Potatoes
- ☐ French fries
- ☐ Greens (collard, spinach)
- ☐ Vegetable/ tomato juice
- ☐ Green salad
- ☐ Broccoli/cauliflower
- ☐ Green beans
- ☐ Carrots
- ☐ Tomatoes
- ☐ Sweet potatoes
- ☐ Green chile/ green pepper

Fruits

- ☐ Apples
- ☐ Oranges
- ☐ Grapefruit
- ☐ Grapes
- ☐ Berries
- ☐ 100% Fruit juice
- ☐ Bananas
- ☐ Pears
- ☐ Melon
- ☐ Peaches
- ☐ Plums

Milk and Other Dairy Products

- ☐ Fat-free (skim) milk
- ☐ Low-fat (½ –1%) milk
- ☐ Reduced-fat (2%) milk
- ☐ Whole milk
- ☐ Flavored milk
- ☐ Soy milk
- ☐ Cheese
- ☐ Yogurt
- ☐ Cottage cheese
- ☐ Ice cream
- ☐ Unfortified or imitation milk

Meat and Meat Alternatives

- ☐ Beef/hamburger
- ☐ Pork
- ☐ Chicken
- ☐ Turkey
- ☐ Fish
- ☐ Cold cuts (hot dogs, lunch meat)
- ☐ Sausage
- ☐ Peanut butter/nuts
- ☐ Eggs
- ☐ Dry beans/peas
- ☐ Tofu

Fats and Sweets

- ☐ Margarine/butter
- ☐ Lard/shortening
- ☐ Gravy
- ☐ Bacon
- ☐ Chips
- ☐ Doughnuts/pastries
- ☐ Pie
- ☐ Cake/cupcakes
- ☐ Jell-o

Other Beverages

- ☐ Regular soft drinks
- ☐ Diet soft drinks
- ☐ Fruit-flavored drinks
- ☐ Coffee/tea
- ☐ Sweet tea
- ☐ Beer/wine/liquor
- ☐ Energy drinks
- ☐ Sports drink (like Gatorade)

28. Does this child currently have any of the following as ***diagnosed by a primary care provider*:**

Problem	Y	N
Failure to thrive		
Dental problems		
Fetal alcohol syndrome		
Cancer		
Celiac Disease		
Central nervous system disorders like epilepsy, cerebral palsy or spina bifida		
Depression		
Developmental, sensory or motor delays interfering with the ability to eat		
Diabetes		
Food allergies List:		
Gastro-Intestinal disorders like ulcers, liver disease, pancreatic problems, or gallbladder disease		
Genetic and congenital disorders like cleft lip, cleft palate, thalassemia major, Down's syndrome, or sickle cell disease		
Hypertension (high blood pressure), prehypertension		
Hypoglycemia (low blood sugar)		
Inborn errors of metabolism like PKU or galactosemia		
Infectious disease like hepatitis, HIV, TB, or AIDS		
Other medical conditions like lupus, heart disease, cystic fibrosis, or asthma with daily medication		
Recent major surgery, accident, or burns		
Renal (kidney) disease		
Thyroid disorders		
Other diagnosed conditions List:		

_____ _____ _____

Signature of person completing this form **Date** **Relationship to child**

DO NOT WRITE BELOW THIS LINE

CPA Signature/Title _____ Date _____