

WIC Nutrition/Health Assessment

Infant

Date _____

(Health Goal: Grow and develop in a nurturing home and learn healthy eating practices.)

Infant's name _____

Infant's date of birth _____

1. How much did the infant weigh at birth?
_____ Pounds _____ Ounces
2. What was the infant's length at birth?
_____ Inches
3. Was the infant born early?
 Yes No
If yes, how many weeks early? _____
4. How many wet diapers does the infant have in a day (24 hours)? _____
How many soiled diapers does the infant have in a day (24 hours)? _____
5. Is the infant currently in foster care?
 Yes No
If yes, has infant changed foster homes in the last 6 months?
 Yes No
6. Does the infant take a vitamin/mineral/herbal supplement?
 Yes No
Does the supplement contain Vitamin D?
 Yes No
7. When does the baby visit a doctor or clinic?
 At regular check-ups
 Just when sick
 Never
8. How would you describe feeding time with the baby?
 Always pleasant
 Usually pleasant
 Sometimes pleasant
 Never pleasant
9. How do you know when the baby is hungry?
 Cries Fussy
 Sucks fingers/hands Other
10. How do you know when the baby is full?
 Falls asleep Turns head Other
 Closes lips Plays/throws food
11. Is the infant lactose intolerant?
 Yes No
12. What type of milk do you feed the baby?
 Breast milk
 Iron-fortified infant formula
Brand name _____
 Low-iron formula
 Cow's milk
 Goat's milk
 Evaporated milk
 Unfortified or imitation milk
 Soy milk

13. If you mix formula, what kind of water do you use?
 Public/tap water Distilled water
 Bottled drinking water Well water
 Nursery water
14. Does this infant's water supply contain fluoride?
 Yes No Unknown
15. How many ounces does the baby usually take at each feeding? _____ Ounces
16. How many feedings does the baby take in 24 hours?

17. What other drinks do you put in the bottle?
 Soda/pop/cola Tea/coffee
 Juice Pedialyte
 Water Other
 Kool-Aid None
18. Is the baby held while he/she is being fed?
 Yes No
19. Does the baby take a bottle to bed at night or carry a bottle around during the day?
 Yes No
20. Is honey, syrup, or sugar added to the baby's bottle or is the baby's pacifier dipped in honey, syrup, or sugar?
 Yes No
21. Are the bottles/nipples used when feeding the baby sterilized?
 Yes No
22. Is there a working stove, oven, and refrigerator where the baby lives?
 Yes No
23. Does the baby 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
24. Which of the following does the baby eat:
 Does not eat solid foods Cereal
 Fruits
 Vegetables Baby dinners
 Meats Toddler foods
 Desserts Eggs
 Table food

This institution is an equal opportunity provider.

Infant's name _____

25. Were any foods other than breast milk or formula introduced to the baby before 4 months of age?

Yes No

26. Is the baby fed cereal or other solid foods from a bottle or infant feeder?

Yes No

27. Is the baby ever fed formula left over from another feeding or fed leftover baby food from the jar?

Yes No

28. What types of things can the baby do?
(Check all that apply.)

- Uses a spoon
- Sits with support
- Drinks from a cup that is held
- Sleeps more than 6 hours at a time
- Brings objects to mouth

29. Did the mother of this infant have any medical/health problems during her pregnancy?

Yes No

Describe: _____

**Breastfeeding Questions
(If not breastfeeding, go to Question 35.)**

30. Does your baby seem satisfied after feedings?

Yes No

31. Is your baby able to latch on without difficulty?

Yes No

32. Do you hear swallowing while your baby nurses?

Yes No

33. Do your breasts feel full before feedings and softer after feedings?

Yes No

34. Are there any breast problems or problems with breastfeeding?

Yes No

Describe: _____

Infant's date of birth _____

35. Does the infant currently have any of the following as **diagnosed by their 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		
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 infant _____

DO NOT WRITE BELOW THIS LINE

CPA Signature/Title _____

Date _____