CHILD NUTRITION QUESTIONS (2 TO 5 YEARS)

Child's Name:	Child's Age:	Child's Birth Date:
Mother's age (circle): 19 yrs & under 20 yrs & over	Name of person completing this form:	

Please circle or write your answers to the following questions:

1. When is your child's next: Doctor appointment? _____ Dentist appointment? _____
2. Has your child had a blood test for LEAD? Yes No I don't know If yes, when? _____
3. What do you give your child? Vitamins Fluoride Iron None
   What medicines do you give your child? _____
4. Which does your child currently have? Allergies Wheezing Rash Constipation Diarrhea None
5. What things, other than food, does your child eat? Dirt Clay Carpet Fibers Cigarette Butts
   Paint Chips Dust Ashes Foam Rubber Crayons None
   Other (list) _____
6. What do you think about your child's weight? OK Too low Too high
7. How often do you run out of money or food stamps (or EBT) to buy food? Often Sometimes Never

8. How many **DAYS each week** does your child get 60 minutes or more of physical activity (such as running around, walking, riding a bike, playing games, sports, swimming)? _____ days each week.
9. How many HOURS each day:
   a. Is a TV on in your house? _____ hours each day
   b. Does your child watch TV, use a computer or play video games? _____ hours each day

Please turn over →

For Staff Use Only
Date: _____ WIC Staff Name: _____

WIC I.D. #: _____ Height _____ Weight _____ Pronto: Y N

Hgb/Hct in ISIS _____YES: Date:_____ _____ No: Referral given

10. Which of these does your child use to eat or drink? (Circle all that apply)
Breastfeeding Bottle Cup Sippy Cup Spoon Fork Fingers

11. How many **TIMES each day** does your child:
a. Eat vegetables (other than French fries)? _____ times each day
b. Eat fruits? _____ times each day
c. Eat sweets and/or salty snacks? (such as chips, candy and cookies) _____ times each day
d. Drink water? _____ times each day
e. Drink juice? _____ times each day
f. Drink soda, Gatorade or sweetened fruit drinks? _____ times each day

12. a. How many times each day does your child drink milk? _____ times each day
b. What type of milk does your child drink most often? Whole 2% 1% Non-fat
Soy Milk Formula Breastmilk Low Lactose Milk Other type of milk

13. Which foods does your child eat often? (Circle all that apply)
- Cheese Yogurt Cottage Cheese Tofu Pudding/Custard
- Vegetables Fruits
- Meat Hotdogs Pork Chicken Turkey Fish Beans/Lentils
  Peanut Butter Hamburger Eggs Nuts
- Breads Cereal Tortillas Pizza Rice Noodles Rolls Crackers Pan Dulce
- Candy Cookies Cakes Donuts Ice Cream Chips
- Other favorite foods (list) _____

14. What food(s) does your child dislike or is unable to eat? _____

15. How many **DAYS each week** does your child:
a. Eat a meal with the family? _____ days each week
b. Eat fried foods (including French fries)? _____ days each week
c. Eat "fast food" or restaurant meals? _____ days each week
d. Eat a meal or snack in front of the TV? _____ days each week

16. How would you describe your child's eating?
OK Picky Eats too much Eats too little Other _____

17. What nutrition and health questions would you like to discuss with your WIC counselor today?

_____

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Circle Chart