OLDER BABY AND CHILD NUTRITION QUESTIONS (5 through 23 months)

Baby's/Child's Name:	Baby's/Child's Age (in months):
Mother's age (circle): 19 years & under 20 years & over	Name of person completing this form:

Please circle or write your answers to the following questions:

1. When is this baby/child's next doctor's appointment?________________________________

2. I give my baby/child: Vitamins Fluoride Iron Drops Medicine None Other ____________

3. My baby/child currently has: Allergies Constipation Diarrhea None of these

4. My baby/child had a blood test for LEAD: No Yes If yes, when? ____________________

5. How often do you run out of money or food stamps (or EBT) to buy food? Often Sometimes Never

6. How do you know when your baby/child is ready to eat? ______________________________
   How do you know when your baby/child is full? ______________________________________

7. If you breastfeed your baby/child:
   How many times in 24 hours (day and night) do you breastfeed? ______________________
   For how long would you like to breastfeed your baby/child?_________________________
   How is breastfeeding going? (not good) 1…..…………2………………3………..……4……….…..…5 (great)

8. If you feed your baby/child formula:
   How often does your baby/child take a bottle of formula? __________________________
   How many ounces of formula does your baby/child drink at each feeding? ______________
   What brand of formula do you give your baby/child? ______________________________
   Explain how you mix the formula. ____
   How is formula feeding going? (not good) 1………..……2……..………3……..………4……………5 (great)

9. Where are all the places your baby/child takes a bottle? Bed Stroller Car Seat
   Held in someone's arms High-Chair Holds his/her own bottle Other ________________

Please turn over →

For Staff Use Only: Date:_________________ WIC Staff Name:___________________________

WIC I.D. #: ______________________ Height _______ Weight __________ Please circle: SR SM SA/SH
Pronto: Y N

Immunization Assessment:

DTaP doses needed by this age:

3 mo.	5 mo.	7 mo.	19 mo.
1	**2**	**3**	**4**

Check (√) current IZ status below for all infants:

__UTD	__Not UTD (Ref. & Ed. given)	__No IZ Card

Hgb/Hct in ISIS: ____YES: Date of Blood Test___________ ___________NO: Referral Given, HOLD Placed

10. What does your baby/child drink from a bottle or cup?

Water	RiceWater	Kool Aid or Punch	Breastmilk
Water with Sugar	Cereal	Soda	Coffee
Water with Honey	Non fat Milk	Lemonade	Tea
Water with Karo Syrup	Lowfat Milk	Juice	Pedialyte
Jell-O Water	Whole Milk	Gatorade	Manzanilla/Chamomile Tea

Other ____

11. What do you feed your baby/child? Family or Table Food Baby Food in Jars Both No food yet

12. Which textures of food do you feed your baby/child?
Pureed Chunky Chopped Soft Pieces Other__________________

13. What foods does your baby/child eat?

Cold/Hot Cereal	Beef/Chicken/Fish	Fruits	Yogurt	Crackers
Rice	Egg Yolk / Egg Whites	Vegetables	Ice Cream	Candy
Noodles/Spaghetti	Peanut Butter	Beans	Pudding/Custard	Nuts
Tortillas	Meat Sticks	Soup	Popsicles	Popcorn
Bread/Toast	Hotdogs	Cheese	Raisins	Cookies
French Fries	Chips	Tofu	Honey	

Other (list)____

14. What things, other than food, does your baby/child eat? Dirt Clay Carpet Fibers
Cigarette Butts Paint Chips Dust Ashes Foam Rubber Crayons
None Other (list) ____

15. My baby/child uses the following to eat and drink: Bottle Cup Sippy Cup
Spoon Fork Fingers

16. How many **HOURS each day**:
a. Is a TV on in your house? __________ hours each day
b. Does your baby/child watch TV, use a computer or play video games? __________ hours each day

17. What nutrition and health questions would you like to discuss with your WIC counselor today?___________
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For Staff Use Only

Circle Chart