

# WIC Nutrition/Health Assessment – Child

Child's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Date \_\_\_\_\_

Please complete the following questions to help WIC staff better understand your child's needs.

1. Which foods/beverages below does your child usually eat or drink?

|                                                                                                                                                                                                                                                                                                                                                                              |                                                                                                                                                                                                                                                                                                                                                                                        |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Breads &amp; Grains:</b><br><input type="checkbox"/> Bread <input type="checkbox"/> Noodles <input type="checkbox"/> Rice<br><input type="checkbox"/> Rolls <input type="checkbox"/> Pasta <input type="checkbox"/> Crackers<br><input type="checkbox"/> Tortillas <input type="checkbox"/> Cereal<br>My child also eats: _____                                           | <b>Vegetables &amp; Fruits:</b><br><input type="checkbox"/> Broccoli <input type="checkbox"/> Potatoes <input type="checkbox"/> Bananas<br><input type="checkbox"/> Green beans <input type="checkbox"/> Corn/Peas <input type="checkbox"/> Oranges<br><input type="checkbox"/> Tomatoes <input type="checkbox"/> Apples <input type="checkbox"/> Berries<br>My child also eats: _____ |
| <b>Meats &amp; Protein:</b><br><input type="checkbox"/> Ground beef <input type="checkbox"/> Lunch meat <input type="checkbox"/> Sausage<br><input type="checkbox"/> Chicken <input type="checkbox"/> Tofu <input type="checkbox"/> Peanut butter<br><input type="checkbox"/> Fish <input type="checkbox"/> Beans <input type="checkbox"/> Pork<br>My child also eats: _____ | <b>Milk &amp; Dairy:</b><br><input type="checkbox"/> Human milk <input type="checkbox"/> Lactose free milk <input type="checkbox"/> Cheese<br><input type="checkbox"/> Cow's milk <input type="checkbox"/> Soymilk <input type="checkbox"/> Yogurt<br><input type="checkbox"/> Formula: _____<br>My child also eats & drinks: _____                                                    |
| <b>Other Beverages:</b><br><input type="checkbox"/> Soft drinks <input type="checkbox"/> Sweet tea <input type="checkbox"/> Unsweet tea<br><input type="checkbox"/> Juice <input type="checkbox"/> Kool-Aid <input type="checkbox"/> Energy drinks<br>My child also drinks: _____                                                                                            | <b>Other Foods:</b><br><input type="checkbox"/> Doughnuts <input type="checkbox"/> Butter/Margarine <input type="checkbox"/> Gravy<br><input type="checkbox"/> Cake <input type="checkbox"/> Cookies <input type="checkbox"/> Chips<br>My child also eats: _____                                                                                                                       |

2. Does your child eat any of the following?

- ☐ Raw or undercooked meat, fish, poultry, eggs
- ☐ Raw sprouts like alfalfa or bean sprouts
- ☐ Unheated lunch meats, hot dogs, processed meats
- ☐ Soft cheeses like Brie, Feta, Queso Fresco
- ☐ Raw or unpasteurized milk or juice

3. Does your child eat any of the following?

- ☐ Popcorn      ☐ Round, Hard Candy
- ☐ Whole grapes      ☐ Nuts or seeds
- ☐ Whole hot dogs      ☐ Marshmallows
- ☐ Peanut Butter      ☐ My child does not eat these

4. Does your child drink water? ☐ Yes      ☐ No

Does the water have fluoride?

- ☐ Yes      ☐ No      ☐ Unsure

5. Does your child use a bottle? ☐ Yes      ☐ No

6. Does your child drink a bottle in bed at night or carry around a bottle or sippy cup?

- ☐ Yes      ☐ No

7. Does your child visit a dentist regularly?

- ☐ Yes      ☐ No

8. Does your child eat or crave non-food items like clay, paint chips, dirt, or ice? ☐ Yes      ☐ No

9. Does your child take daily vitamins or minerals?

- ☐ Yes      ☐ No

If yes, are they taken as instructed?

- ☐ Yes      ☐ No      ☐ Unsure

Does your child take a supplement with vitamin D?

- ☐ Yes      ☐ No      ☐ Unsure

Does your child take herbal or botanical supplements? ☐ Yes      ☐ No

10. Do you feel you have enough food to feed your family? ☐ Yes      ☐ No

11. Has your child entered the foster care system in the last 6 months? ☐ Yes      ☐ No

Has your child changed foster homes in the last 6 months? ☐ Yes      ☐ No

12. Does your child visit a doctor for routine check-ups? ☐ Yes      ☐ No

13. List any health issues your child has:

\_\_\_\_\_

14. Have these issues been diagnosed by your child's doctor? ☐ Yes      ☐ No

15. If you could wish for one healthy habit for your child in the next six months, what would it be?

\_\_\_\_\_

This institution is an equal opportunity provider.

----- THIS SIDE IS FOR WIC STAFF TO COMPLETE -----

Below are suggested questions to facilitate WIC discussion.

- Tell me about your child's eating. (*Assess eating behaviors, self-feeding, uses a cup/weaned from bottle, planned meals/snacks and only water between*)
- What are your mealtimes like? (*Assess family meals, is mealtime enjoyable, environment at table [no TV/phones/tablets, comfortable/secure seating for child], developmentally appropriate foods*)
- What concerns do you have about your child's health? Activity level? Growth?
- How do you care for your child's teeth and gums?
- What has been helpful at this visit?

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