

WIC Nutrition/Health Assessment – Postpartum Woman

Name _____ Date of Birth _____ Date _____

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

1. Which foods/beverages below do you usually eat or drink?

Breads & Grains: ☐ Bread ☐ Noodles ☐ Rice ☐ Rolls ☐ Pasta ☐ Crackers ☐ Tortillas ☐ Cereal I also eat: _____	Vegetables & Fruits: ☐ Broccoli ☐ Potatoes ☐ Bananas ☐ Green beans ☐ Corn/Peas ☐ Oranges ☐ Tomatoes ☐ Apples ☐ Berries I also eat: _____
Meats & Protein: ☐ Ground beef ☐ Lunch meat ☐ Sausage ☐ Chicken ☐ Tofu ☐ Peanut butter ☐ Fish ☐ Beans ☐ Pork I also eat: _____	Milk & Dairy: ☐ Cow's milk ☐ Lactose free milk ☐ Yogurt ☐ Soymilk ☐ Cottage cheese ☐ Cheese I also eat & drink: _____
Other Beverages: ☐ Soft drinks ☐ Sweet tea ☐ Unsweet tea ☐ Juice ☐ Coffee ☐ Energy drinks I also drink: _____	Other Foods: ☐ Doughnuts ☐ Butter/Margarine ☐ Gravy ☐ Cake ☐ Cookies ☐ Chips I also eat: _____

2. Are you on a special diet to lose weight?

☐ Yes ☐ No

3. Have you used starvation, diet pills, laxatives, or vomiting as a method to lose weight in the past 12 months? ☐ Yes ☐ No

4. Have you ever had bariatric surgery?

☐ Yes ☐ No

5. Are you often constipated or have problems with bowel movements? ☐ Yes ☐ No

6. How many glasses of water do you drink daily?
_____ glasses

7. How often are you physically active? ____ x per wk

8. Do you take daily vitamins or minerals?

☐ Yes ☐ No

If yes, do you take as instructed?

☐ Yes ☐ No ☐ Unsure

Do you take a supplement with folic acid?

☐ Yes ☐ No ☐ Unsure

Do you take a supplement with iodine?

☐ Yes ☐ No ☐ Unsure

Do you take herbal or botanical supplements?

☐ Yes ☐ No

9. Do you eat/crave non-food items like clay, paint chips, dirt, or ice? ☐ Yes ☐ No

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

11. Did you have gestational diabetes or preeclampsia with any pregnancy? ☐ Yes ☐ No

12. Have you discussed family planning options (birth control) with your doctor? ☐ Yes ☐ No

13. What health issues do you have?

14. In your most recent pregnancy, did you have a miscarriage, or death of a fetus > 20 weeks (stillborn), delivered a baby who died within 28 days of birth? ☐ Yes* ☐ No

*If yes, skip to question #20.

15. Did your last baby weigh 5 pounds 8 ounces or less at birth? ☐ Yes ☐ No

16. Did your last baby weigh 9 pounds or more at birth? ☐ Yes ☐ No

17. Did your last baby have a congenital birth defect like neural tube defect, cleft palate, or cleft lip? ☐ Yes ☐ No

18. Was your last baby born early? ☐ Yes ☐ No

19. Are you currently breastfeeding? ☐ Yes ☐ No
If yes, how is breastfeeding going?

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

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Below are suggested questions to facilitate WIC discussion.

- How are you feeling today? *(Assess for 'baby blues'/depression, postpartum support, appetite, skipping meals [concern about adequate calories & nutrients])*
- What are your mealtimes like? *(Assess environment [TV, phones, tablets at table], family meals, timing of meals, pattern [3 meals/2-3 snack], intake changes, intolerances, any special dietary needs, food preparation [who prepares, fast food/wk])*
- What would you like to change about your eating? Activity level?
- Is there anything you would like to eat more or less of?
- What questions do you have about breastfeeding? *(Assess support system, nipple pain, latch, milk expression/pumping, milk supply concerns whether breastfeeding or nonbreastfeeding)*
- Do you ever have a hard time chewing or eating certain foods? *(tooth loss, impaired ability to eat, oral health)*
- What has been helpful at this visit?

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