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:
☐ Hamburger ☐ 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 currently breastfeeding? ☐ Yes ☐ No
   How is breast feeding going? _____
   _____
3. Are you on a special diet or diet to lose weight?
   ☐ Yes ☐ No
4. Have you used starvation, diet pills, laxatives, or vomiting as a method to lose weight in the past 12 months? ☐ Yes ☐ No
5. Have you ever had bariatric surgery?
   ☐ Yes ☐ No
6. Are you often constipated or have problems with bowel movements? ☐ Yes ☐ No
7. How many glasses of water do you drink daily?
   _____ glasses
8. How often are you physically active? ___X per wk
9. Do you take daily vitamins or minerals?
   ☐ Yes ☐ No
   Does the supplement have iodine?
   ☐ Yes ☐ No ☐ Unsure
   Do you take herbal or botanical supplements?
   ☐ Yes ☐ No
10. Do you eat/crave non-food items like clay, paint chips, dirt, or ice? ☐ Yes ☐ No
11. Do you feel you have enough food to feed your family? ☐ Yes ☐ No
12. Did your last baby weigh 5 pounds 8 ounces or less at birth? ☐ Yes ☐ No
13. Did your last baby weigh 9 pounds or more at birth? ☐ Yes ☐ No
14. Did your last baby have a congenital birth defect like neural tube defect, cleft palate, or cleft lip?
    ☐ Yes ☐ No
15. Was your last baby born early?
    ☐ Yes, _____ wks ☐ No
16. Did you have gestational diabetes or preeclampsia with any pregnancy? ☐ Yes ☐ No
17. In your most recent pregnancy, did you have a miscarriage, or death of a fetus ≥ 20 weeks (stillborn), or delivered a baby who died within 28 days of birth? ☐ Yes ☐ No
18. Have you discussed family planning options (birth control) with your doctor?
    ☐ Yes ☐ No
19. What health issues do you have? _____
    _____
20. If you could wish for one healthy habit for yourself 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.

- 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?

- If breastfeeding, how is breastfeeding going? *(Assess support system, nipple pain, latch, milk expression/pumping)*

- 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?