CHILD HEALTH AND DIET QUESTIONS

(1 through 4 years of Age)

Michigan Department of Health and Human Services

Today's date

Your child's name	Your child's birth date: Month/Day/Year _____	Is your child a: ☐ Boy ☐ Girl

The following question is optional. Your answer will be used for reporting purposes. If you do not answer, the staff will make a selection for you. This does not affect you receiving WIC benefits.

Is your child Hispanic or Latino? ☐ Yes ☐ No	Is your child Arabic? ☐ Yes ☐ No	Check **all** races that apply to your baby: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White

What was your child's birth weight?
_____ pounds _____ ounces

When was your child born? Month/Day/Year_____	What was your due date? Month/Day/Year_____

Note to Staff: Calculate Weeks gestation with client's response and validate with EDD/ADD if available.

Medical Information

1. **Medical conditions**/recent illnesses: WIC staff will give you a list of medical conditions to review.

2. Does your child take any **medicines**?
   ☐ Yes ☐ No
   If yes, what kind? _____
   Any side effects?
   ☐ Yes ☐ No
   If yes, what? _____

3. Does your child have any **dental/oral problems** that make it difficult to eat?
   ☐ Yes ☐ No
   If yes, what kind? _____

4. Mother's Height: _____ feet _____ inches

5. Mother's Weight: _____ pounds

   This should be answered by the **biological mother** only. What is your current height and weight? (OR if you are pregnant now or had a baby in the past 6 months, what was your weight before that pregnancy?)

5. Father's Height: _____ feet _____ inches
   (This should be answered by the **biological father** only)

6. Father's Weight: _____ pounds

6. Does anyone living in your **household smoke** inside the home? (CDC)
   ☐ Yes
   ☐ No
   ☐ Unknown

7. About how many hours did your child sit and **watch television** or videos yesterday? (CDC)
   ☐ > 0 and < 1 hour
   ☐ 1 hour
   ☐ 2 hours
   ☐ 3 hours
   ☐ 4 hours
   ☐ 5 or more hours
   ☐ None
   ☐ Unknown

BF Statistics Tab (CDC)

Was this child ever breastfed or fed breast milk?

☐ Yes
☐ No
☐ Unknown

Is this child currently breastfed?

☐ Yes ☐ No

How old was this child when he/she was **first fed** something other than breast milk?

☐ Exclusively Breastfed **(Check here if child has never had anything except breast milk)**

Age: _____ Month _____ Weeks _____Days ☐ Unknown

Type of Food:

☐ Cereal
☐ Cow's Milk
☐ Formula
☐ Fruit Juice
☐ Vegetable
☐ Water
☐ No Information Provided

(Answer the next question if your child is no longer getting breast milk)

How old was this child when he/she completely stopped breastfeeding or being fed by breast milk?

Age: _____ Month _____ Weeks _____Days ☐ Unknown

Reason Breastfeeding Ended:

☐ Baby Distracted
☐ Breast/Nipple Pain
☐ Doctor Recommended
☐ Infant/Child Illness/Condition
☐ Lack of Support
☐ Latch Issues/Refused Breast
☐ Low Milk Supply
☐ Maternal Illness/Surgery
☐ Medication
☐ Mother's Preference
☐ Return to School
☐ Return to Work
☐ Teething
☐ Other _____
☐ No Information Provided

Nutrition History

1. If breastfed, how old was this child when he/she was **routinely** fed something other than breast milk?
   Age: _____ Month _____ Weeks _____Days ☐ Unknown

Type of Food Choices:

☐ Cereal
☐ Cow's Milk
☐ Formula
☐ Meat
☐ Fruit
☐ Juice
☐ Vegetable
☐ Water

2. How many **meals** does your child eat most days? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 or more

3. How many **snacks** does your child eat most days? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 or more

4. How many ounces of **milk** does your child drink most days? _____ Ounces

   Does your child eat yogurt or cheese?

   ☐ Yes ☐ No

   How much on most days? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 or more

5. How many ounces of **juice** does your child drink most days? _____ Ounces

6. Is your child's **appetite** usually: ☐ Good ☐ Fair ☐ Poor

7. Is your child on a **special diet** (prescribed by your doctor)?

☐ Yes ☐ No

If yes, what kind? _____

8. How many times a week does your child eat **Fast Food**? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 or more

9. Does your child have any food allergies?

☐ Yes ☐ No

If yes, what? _____

10. Does your child eat or drink any of the following every day or most days? (Check all that apply):

☐ Skim, ½%, 1%, or 2%
☐ Milk substitutes (rice milk, soy milk, non-dairy creamer, sweetened condensed milk or homemade milks)
☐ Pop, Kool-Aid, Sports drinks, flavored water, sweet tea, Jell-O water
☐ Baby Food or blenderized food only
☐ None Apply

11. Does your child eat or drink any of the following? (Check all that apply)

☐ Raw (unpasteurized) juice or milk
☐ Soft cheese (feta, Camembert, Brie, queso blanco, queso fresco, Panela)
☐ Raw or undercooked (rare) meat, fish, poultry or eggs
☐ Michigan fish
☐ Raw sprouts
☐ Hot dogs, lunchmeats, and other deli meats not reheated to steaming hot
☐ Raw tofu
☐ None apply

12. Does your child? (Check all that apply)

☐ Use a bottle
☐ Sleep with a bottle
☐ Use a bottle all through the day or as a pacifier
☐ Take cereal or other food in a bottle
☐ Drink juice in a bottle
☐ Sip from a training or sippy cup all day long
☐ Use a pacifier dipped in sugar, honey or syrup
☐ None apply

13. Does your child? (Check all that apply)

☐ Eat a strict vegetarian diet
☐ Eat a low calorie/weight loss diet
☐ Regularly eat non-food items (ashes, carpet fibers, cigarettes or cigarette butts, clay, dust, foam rubber, paint chips, soil, laundry or corn starch)
☐ Have to eat when he/she doesn't want to
☐ Eat only by being spoon-fed (child never feeds self with spoon, fingers, etc.)
☐ Choke on his/her food often
☐ Take a fluoride supplement
☐ Take a vitamin or mineral supplement daily What kind? _____
☐ Have history of bariatric surgery
☐ Use herbal supplement remedies or teas What kind? _____
☐ None apply

14. Has your child been in **foster care** in the past months?

☐ Yes ☐ No

15. Does a family member have a **disability** that would make it difficult to plan or prepare food for your child?

☐ Yes ☐ No

Staff Notes

CPA Signature	**Date**

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, disability, age, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA. Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English. To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by: mail: U.S. Department of Agriculture, Office of the Assistant Secretary for Civil Rights, 1400 Independence Avenue, SW, Washington, D.C. 20250-9410; fax: (202) 690-7442; or email: program.intake@usda.gov. This institution is an equal opportunity provider.

Authority: Act 368 PA 1978	The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.