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?	Race: Select one or more:	
☐ Yes ☐ No	☐ American Indian or Alaska Native	☐ White
	☐ Asian	☐ European
	☐ Black or African American	☐ North African
	☐ Native Hawaiian or Other Pacific Islander	☐ Middle Eastern

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

6. Father's Weight: _____ pounds

   (This should be answered by the **biological father** only)

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
☐ 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**

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