Child Health and Diet Questions

1 through 4 years of Age
Certification and Recertification

Today's date: _____/_____/_____

Your child's name: _____

Your child's birth date: _____/_____/_____

Is your child Boy or 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 child:

- ☐ 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 Screen

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

2. Check here if your child takes any **medicines:** ☐ If yes, what kind? _____

   Any side effects? ☐ Yes ☐ No

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: ____ ft ____ in 5. Mother's Weight: ____ lb

   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?)

6. Father's Height: ____ ft ____ in 7. Father's Weight: ____ lb

   This should be answered by the **biological father** only.

8. Does anyone living in your **household smoke** inside the home? (CDC)

   ☐ Yes ☐ No ☐ Unknown

9. 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)**

Months Weeks Days

Age: ☐ ☐ ☐ ☐ Unknown

Type of Food (Circle One)

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

(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 breast milk?

Months Weeks Days

Age: ☐ ☐ ☐ ☐ Unknown

Reason Breastfeeding Ended (Circle One)

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
No Information Provided
Other
Return to School
Return to Work
Teething

Nutrition History Screen

1. If breastfed, how old was this child when he/she was **routinely** fed something other than breast milk?

   ☐ Months ☐ Weeks ☐ Days

   Type of Food Choices: ☐ Cereal ☐ Cow's Milk ☐ Formula ☐ Meat
   ☐ Fruit ☐ Juice ☐ Vegetable ☐ Water

2. Number of **Meals** your child usually eats in a day:
   ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 or more

3. Number of **Snacks** your child usually eats in a day:
   ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 or more

4. How many ounces of **milk** does your child drink most days? ☐
   Does your child eat yogurt or cheese? Y or N How much on most days? ☐

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

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

7. Check here if your child is on a **special diet**: ☐ 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**? If yes, to 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, Koolaid, 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
- ☐ None apply
- ☐ Raw sprouts
- ☐ Raw tofu
- ☐ Hot dogs, lunchmeats, and other deli meats <u>not reheated to steaming hot</u>
- ☐ Michigan fish

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 <u>all day long</u>
- ☐ 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 daily
- ☐ Take a vitamin/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 6 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** _____