CHILD (2–4 YEARS) NUTRITION QUESTIONS

Please circle or write your answers to the following questions:

1. When is your child’s next doctor’s appointment? ________________ Dentist? ________________

2. What do you give your child? Vitamins/Minerals Fluoride Iron None
   Other Medications (list) ____________________________

3. My child currently has: Allergies Wheezing Rash Constipation Diarrhea None

4. What things, other than food, does your child eat? Dirt Clay Carpet Fibers Laundry Starch
   Cigarette Butts Paint Chips Dust Ashes None Other (list) ____________________________

5. Has your child had a blood lead test? Yes No If yes, when? ____________________________

6. How would you describe your child’s eating? OK Picky Too much Not enough Other ____________________________

7. How many times a week does an adult eat a meal with your child?
   Never 1-3 times 4-6 times 7 or more times ____________________________

8. Who prepares the meals for your family? ____________________________

9. How would you describe meals with your family?
   Usually pleasant Sometimes pleasant Not pleasant Other ____________________________

10. How many times a week does your family eat fast food or food from a restaurant?
    Never 1-2 times 3-4 times 5 or more times ____________________________

11. What does your child eat/drink on most days?
    ♦ Juice Soda Kool Aid/Punch Gatorade Water
    ♦ Fruits Vegetables
    ♦ Milk (Skim Lowfat Whole) Cheese Yogurt Cottage Cheese Pudding/Custard
    ♦ Meat Hotdogs Chicken Turkey Fish Tofu Beans/Lentils Peanut Butter Eggs Nuts
    ♦ Breads Cereal Tortillas Rice Noodles Rolls Crackers Pan Dulce
    ♦ Candy Cookies Cakes Donuts Ice Cream Chips French Fries
    ♦ Other (list) ____________________________

12. What are your child’s favorite food(s)? ____________________________

13. What food(s) does your child dislike or is unable to eat? ____________________________

14. My child uses the following to eat or drink: Breast Bottle Cup Spoon Fork Fingers

15. What do you think about your child’s size? Too little Too big OK ____________________________

16. What kinds of activity does your child do? ____________________________

17. How many hours is a TV on (includes video games, movies, gameboy) in your house each day? ________

18. Do you ever run out of money or food stamps to buy food? Yes No ____________________________

19. What nutrition and health questions do you have today? ____________________________

For Staff Use Only

Date: ________________ WIC Staff Name: ____________________________

Participant WIC ID#: ____________________________ Height: ________________ Weight: ________________