Child Questionnaire

Child’s Name _____________________________________  Date _________________________

Name of person completing form ____________________ __  Relationship to child______________

Please answer these questions to help with your WIC visit today.

1. Does anyone smoke inside your home?  □ Yes  □ No

2. What does your household use for drinking water?  □ city/town/county water  □ well water  □ bottled water  □ other

3. Does the refrigerator in your home work?  □ Yes  □ No

4. Does the stove in your home work?  □ Yes  □ No

5. In the past month, have there been days when you did not have enough food or money to buy food?  □ Yes  □ No

6. When was your child’s last visit to the doctor?

7. Has the doctor said your child has any health problems?  □ Yes  □ No
   If “yes”, list problem(s):

8. What concerns do you have about your child’s health?

9. Most days, do you brush your child’s teeth?  □ Yes  □ No

10. Which of these does your child take?
    □ multi-vitamins  □ iron supplement  □ fluoride supplement  □ medicine from doctor
    □ over-the-counter medicine (like pain relievers, antacids, laxatives)  □ herbal supplement
    □ other ________________________________  □ none

11. Are your child’s shots up-to-date?  □ Yes  □ No

12. Does your child follow a special diet or drink a special formula?  □ Yes  □ No
    If “yes”, what kind of diet or formula?

13. On most days, how many times does your child eat?
    number of meals _________________________ number of snacks _________________________

    turn page over →
14. How many times a week does your child eat meals and snacks away from home or eat take-out meals (not including meals at child care)? It includes vending machines, fast foods, delis and all types of restaurants.
   □ never or rarely □ 1-3 times a week □ 4-6 times a week □ more than 6 times a week □ not sure

15. Does your child eat fruit every day? □ Yes □ No

16. Does your child eat vegetables every day? □ Yes □ No

17. What kind of milk does your child drink?
   □ skim or fat-free □ 1% low-fat □ 2% low-fat □ whole □ not sure □ none
   □ other ___________________________

18. Which of these does your child drink everyday?
   □ milk □ water □ flavored water □ fruit juice □ fruit drinks or punch
   □ regular soda □ sweet tea □ sports drinks □ other ___________________________

19. Check any of the following your child uses for drinking?
   □ regular cup □ cup with lid and spout (sippy cup) □ baby bottle

20. Does your child feed him or herself? □ Yes □ No
   If “yes”, how? □ with fork or spoon □ with fingers

21. Check any of the following foods your child eats:
   □ raw or unpasteurized milk
   □ soft cheeses like feta, brie, blue Cheese or queso fresco or blanco
   □ raw or undercooked meat or poultry, fish (including sushi), shellfish, eggs or tofu
   □ none

22. Check any of the following items your child eats:
   □ ashes □ baking soda □ carpet fibers □ chalk □ cigarette butts
   □ clay □ dirt □ ice □ matches □ paint chips
   □ starch (corn or laundry) □ other ___________________________ □ none

23. How often does your child have some active play time (like running, jumping, or playing outside)?
   □ most days □ some days □ not very often

24. How many hours a day does your child watch TV?
   □ 3 or more hours □ 2-3 hours □ 1-2 hours □ less than 1 hour □ doesn’t watch TV every day

25. What would you like to talk to the nutritionist about today?

Thank you!