

Child Food Questions (Please fill out for your children on WIC)

My children usually eat _____ meals a day and _____ snacks a day.

Most of the time my children eat well. (circle a number below)

Do not agree 0 1 2 3 4 5 Strongly agree

My child is often a picky eater. (circle a number below)

Do not agree 0 1 2 3 4 5 Strongly agree

My child eats fast food: 1 time/week or less 2-4 times/week 5 times/week or more

My child eats fruit: 1 cup/day or less 2 cups/day 3 cups/day or more

My child eats vegetables: 1 cup/day or less 2 cups/day 3 cups/day or more

I think my child should eat more (List foods) _____

I think my child should eat less (List foods) _____

What do your children drink? (check all that apply) (425.1, 425.2, 425.5)

- | | | | |
|--------------------------------------|--|------------------------------------|--|
| <input type="checkbox"/> Water | <input type="checkbox"/> Breast milk | <input type="checkbox"/> Formula | <input type="checkbox"/> Pedialyte |
| <input type="checkbox"/> Whole Milk | <input type="checkbox"/> 2% or 1% Milk | <input type="checkbox"/> Skim Milk | <input type="checkbox"/> Raw Milk |
| <input type="checkbox"/> Dry Milk | <input type="checkbox"/> Evaporated Milk | <input type="checkbox"/> Rice Milk | <input type="checkbox"/> Soy Milk |
| <input type="checkbox"/> Juice | <input type="checkbox"/> Raw Juice | <input type="checkbox"/> Soda | <input type="checkbox"/> Tang/Kool-Aid |
| <input type="checkbox"/> Fruit Drink | <input type="checkbox"/> Sweet Tea | <input type="checkbox"/> Capri Sun | <input type="checkbox"/> Other _____ |

My children drink from: (check all that apply) Sippy Cup Cup Baby bottle* (419, 425.3)

*If bottle is used, how many bottles are given in 24 hours? _____

• What is in the bottle? _____

• When does your child get a bottle? (check all that apply)

Bedtime/naptime Mealtime all day

When would you like to have your child off the bottle? _____

Do you have any concerns about you or your child? (check all that apply) (425.4)

No problems constipation diarrhea Vomiting

chewing/swallowing choking/gagging Meal time behavior picky eater

other concerns: _____

Is your child on a special diet? No Yes, Describe _____ 425.6

Does your child have any food allergies? No Yes, List _____

Does your child ever eat non-food things, like dirt, clay, soap, ice, or cigarette butts?

No Yes, Describe: _____ 425.9

Do you run out of money or Food Stamps to buy food? No Yes Sometimes

Do you worry someone you know will hurt your child? No Yes Sometimes

List any medications, vitamins, minerals, or herbal supplements your children are

taking. Please List _____

Which child/children? _____ (425.7, 425.8)