WIC Nutrition/Health Assessment

Infant

Date _____

(Health Goal: Grow and develop in a nurturing home and learn healthy eating practices.)

Infant's name _____ **Infant's date of birth** _____

1. How much did the infant weigh at birth?
   _____ Pounds _____ Ounces
2. What was the infant's length at birth?
   _____ Inches
3. Was the infant born early?
   ☐ Yes ☐ No
   If yes, how many weeks early? _____
4. How many wet diapers does the infant have in a day (24 hours)? _____
   How many soiled diapers does the infant have in a day (24 hours)? _____
5. Is the infant currently in foster care?
   ☐ Yes ☐ No
   If yes, has infant changed foster homes in the last 6 months?
   ☐ Yes ☐ No
6. Does the infant take a vitamin/mineral/herbal supplement?
   ☐ Yes ☐ No
   Does the supplement contain Vitamin D?
   ☐ Yes ☐ No
7. When does the baby visit a doctor or clinic?
   ☐ At regular check-ups
   ☐ Just when sick
   ☐ Never
8. How would you describe feeding time with the baby?
   ☐ Always pleasant
   ☐ Usually pleasant
   ☐ Sometimes pleasant
   ☐ Never pleasant
9. How do you know when the baby is hungry?
   ☐ Cries ☐ Fussy
   ☐ Sucks fingers/hands ☐ Other
10. How do you know when the baby is full?
    ☐ Falls asleep ☐ Turns head ☐ Other
    ☐ Closes lips ☐ Plays/throws food
11. Is the infant lactose intolerant?
    ☐ Yes ☐ No
12. What type of milk do you feed the baby?
    ☐ Breast milk
    ☐ Iron-fortified infant formula
    Brand name _____
    ☐ Low-iron formula
    ☐ Cow's milk
    ☐ Goat's milk
    ☐ Evaporated milk
    ☐ Unfortified or imitation milk
    ☐ Soy milk
13. If you mix formula, what kind of water do you use?
    ☐ Public/tap water ☐ Distilled water
    ☐ Bottled drinking water ☐ Well water
    ☐ Nursery water
14. Does this infant's water supply contain fluoride?
    ☐ Yes ☐ No ☐ Unknown
15. How many ounces does the baby usually take at each feeding? _____ Ounces
16. How many feedings does the baby take in 24 hours?
17. What other drinks do you put in the bottle?
    ☐ Soda/pop/cola ☐ Tea/coffee
    ☐ Juice ☐ Pedialyte
    ☐ Water ☐ Other
    ☐ Kool-Aid ☐ None
18. Is the baby held while he/she is being fed?
    ☐ Yes ☐ No
19. Does the baby take a bottle to bed at night or carry a bottle around during the day?
    ☐ Yes ☐ No
20. Is honey, syrup, or sugar added to the baby's bottle or is the baby's pacifier dipped in honey, syrup, or sugar?
    ☐ Yes ☐ No
21. Are the bottles/nipples used when feeding the baby sterilized?
    ☐ Yes ☐ No
22. Is there a working stove, oven, and refrigerator where the baby lives?
    ☐ Yes ☐ No
23. Does the baby eat any of the following:
    ☐ Raw or undercooked meat, fish, poultry, or eggs
    ☐ Unpasteurized milk/soft cheeses
    ☐ Unheated lunch meats, hot dogs, or other processed meats
    ☐ Raw vegetable sprouts
    ☐ Unpasteurized juice
    ☐ None
24. Which of the following does the baby eat:
    ☐ **Does not eat solid foods** ☐ Cereal
    ☐ Vegetables ☐ Fruits
    ☐ Meats ☐ Baby dinners
    ☐ Desserts ☐ Toddler foods
    ☐ Table food ☐ Eggs

Infant's name _____

25. Were any foods other than breast milk or formula introduced to the baby before 4 months of age?
    ☐ Yes ☐ No

26. Is the baby fed cereal or other solid foods from a bottle or infant feeder?
    ☐ Yes ☐ No

27. Is the baby ever fed formula left over from another feeding or fed leftover baby food from the jar?
    ☐ Yes ☐ No

28. What types of things can the baby do? (*Check all that apply.)*
    ☐ Uses a spoon
    ☐ Sits with support
    ☐ Drinks from a cup that is held
    ☐ Sleeps more than 6 hours at a time
    ☐ Brings objects to mouth

29. Did the mother of this infant have any medical/health problems during her pregnancy?
    ☐ Yes ☐ No
    Describe: _____

Breastfeeding Questions
(If not breastfeeding, go to Question 35.)

30. Does your baby seem satisfied after feedings?
    ☐ Yes ☐ No

31. Is your baby able to latch on without difficulty?
    ☐ Yes ☐ No

32. Do you hear swallowing while your baby nurses?
    ☐ Yes ☐ No

33. Do your breasts feel full before feedings and softer after feedings?
    ☐ Yes ☐ No

34. Are there any breast problems or problems with breastfeeding?
    ☐ Yes ☐ No
    Describe: _____

Infant's date of birth _____

35. Does the infant currently have any of the following as ***diagnosed by their primary care provider:***

Problem	Y	N
Failure to thrive		
Dental problems		
Fetal alcohol syndrome		
Cancer		
Celiac Disease		
Central nervous system disorders like epilepsy, cerebral palsy or spina bifida		
Developmental, sensory or motor delays interfering with the ability to eat		
Diabetes		
Food allergies List:		
Gastro-Intestinal disorders like ulcers, liver disease, pancreatic problems, or gallbladder disease		
Genetic and congenital disorders like cleft lip, cleft palate, thalassemia major, Down's syndrome, or sickle cell disease		
Hypertension (high blood pressure), prehypertension		
Hypoglycemia (low blood sugar)		
Inborn errors of metabolism like PKU or galactosemia		
Infectious disease like hepatitis, HIV, TB, or AIDS		
Other medical conditions like lupus, heart disease, cystic fibrosis, or asthma with daily medication		
Recent major surgery, accident, or burns		
Renal (kidney) disease		
Thyroid disorders		
Other diagnosed conditions List:		

_____ _____ _____
Signature of person completing this form **Date** **Relationship to infant**

DO NOT WRITE BELOW THIS LINE

CPA Signature/Title _____ Date _____