Nutrition Screening Questionnaire

Today's date _____ Parent _____ Home Phone _____
Address _____

How is your Child Eating and Growing? *(Please circle yes or no in response to the following questions)*

1. Is it easy to tell when your child is hungry or thirsty? Yes No
2. Do you worry about his/her eating or growing? Yes No
3. Have you received any special directions for feeding your child? Yes No
4. Does he/she take vitamins or minerals? Yes No If yes, what? _____
5. Does he/she take medications? Yes No If yes, what? _____
6. Does your child eat anything that is not food, such as paint or dirt? Yes No
7. Do you have trouble buying or making your child's food? Yes No
8. Is your child on the WIC program? Yes No If yes, where? _____
9. Does your child go to a daycare or school? Yes No If yes, where? _____
10. Is your child fed by any other people? Yes No If yes, who? _____

What Does Your Child Eat and Drink?

11. Where do you usually feed your child? _____
12. How many meals and snacks does he/she eat most days? _____ Meals _____ Snacks
13. How long does it take your child to eat? _____ Minutes
14. Please check what your child eats:

____ Breastmilk	_____ Baby Cereal	_____ Ground Meats/Finely Ground Table Foods
____ Formula	_____ Strained Baby Foods	_____ Cut Up Meats/Soft Table Foods
____ Cow's Milk	_____ Junior Foods	_____ Finger Foods

15. Circle the foods that you feel your child does not eat enough of:
    1. milk and milk products 2. meat, beans, eggs 3. fruit and vegetables 4. breads and cereals

16. How much does your child usually drink in one day (24 hours):
    Water _____ Sweet drinks _____ Juice _____ Cow's milk _____
    Baby formula _____ What kind of formula? (with/without iron?) _____
    How do you mix the formula? _____

Are Any of These a Problem for Your Child? *If yes, please check.*

_____ vomiting	_____ gagging and choking	_____ eating too slowly
_____ diarrhea	_____ chewing	_____ refusing to eat
_____ constipation	_____ cup drinking	_____ spitting out food
_____ sucking on nipple	_____ finger feeding	_____ getting upset at meals
_____ holding up head	_____ not eating solid foods after 1 yr.	_____ poor appetite/picky eater
_____ sitting up alone	_____ bad teeth/sore mouth	_____ not self-feeding
_____ swallowing	_____ food allergies	

Other concerns: _____
_____

PHN please complete

DX _____
Height _____ Weight _____ %tiles: Ht/age _____ Wt/age _____ Wt/Ht _____
Birthweight (≤ 2 years) _____ OFC _____ Hematocrit _____ % Hemoglobin _____ Gm/dl _____
Comments: _____
_____
Medical Care Provider _____ Phone _____
PHN _____ Clinic _____ Phone _____

Seattle-King County
Department of Public Health
CS #13.19.87 Rev. 5/90
NUTRQUES.PM3

Name _____

_____
DOB Patient I.D.#