



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES  
WIC AND NUTRITION SERVICES

**WIC NUTRITION ASSESSMENT FOR CHILDREN AGES 1-5**

CHILD'S NAME: _____	AGE: <input checked="" type="checkbox"/> MONTH RANGE <input type="checkbox"/> 12-23 <input type="checkbox"/> 24-59	DATE COMPLETED: _____																		
<p>1. Is your child following a special diet? ..... <input type="checkbox"/> Yes   <input type="checkbox"/> No   <b>[341- 362] [425.6]</b></p> <p>If yes, select:   <input type="checkbox"/> Vegetarian   <input type="checkbox"/> Vegan   <input type="checkbox"/> Low calorie/weight loss  <input type="checkbox"/> Macrobiotic   <input type="checkbox"/> Food allergy   <input type="checkbox"/> Tube Feeding   <input type="checkbox"/> Other: _____</p> <p>If yes, is there a medical condition related to this diet? ..... <input type="checkbox"/> Yes   <input type="checkbox"/> No</p>																				
<p>2. Which of the following foods does your child eat? (Select all that apply): <b>[425.5]</b></p> <table style="width:100%; border: none;"> <tr> <td><input type="checkbox"/> Fresh squeezed fruit or vegetable juices</td> <td><input type="checkbox"/> Uncooked luncheon meats, deli meats, hot dogs</td> </tr> <tr> <td><input type="checkbox"/> Raw or undercooked meats, fish, chicken, turkey or eggs</td> <td><input type="checkbox"/> Unpasteurized (farm fresh) dairy products</td> </tr> <tr> <td><input type="checkbox"/> Soft cheeses such as Feta, Brie, Camembert, Blue-veined cheese, Queso Blanco, Queso Fresco</td> <td><input type="checkbox"/> Raw sprouts (alfalfa, clover, bean, radish)</td> </tr> <tr> <td></td> <td><input type="checkbox"/> None of the above</td> </tr> </table>			<input type="checkbox"/> Fresh squeezed fruit or vegetable juices	<input type="checkbox"/> Uncooked luncheon meats, deli meats, hot dogs	<input type="checkbox"/> Raw or undercooked meats, fish, chicken, turkey or eggs	<input type="checkbox"/> Unpasteurized (farm fresh) dairy products	<input type="checkbox"/> Soft cheeses such as Feta, Brie, Camembert, Blue-veined cheese, Queso Blanco, Queso Fresco	<input type="checkbox"/> Raw sprouts (alfalfa, clover, bean, radish)		<input type="checkbox"/> None of the above										
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<p>3. Does your child routinely eat things that are non-food items? ..... <input type="checkbox"/> Yes   <input type="checkbox"/> No   <b>[425.9]</b></p> <p>If yes, select all that apply:</p> <table style="width:100%; border: none;"> <tr> <td><input type="checkbox"/> Ashes</td> <td><input type="checkbox"/> Clay</td> <td><input type="checkbox"/> Paint chips</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Carpet fibers</td> <td><input type="checkbox"/> Dust</td> <td><input type="checkbox"/> Paper</td> <td><input type="checkbox"/> Starch (laundry or cornstarch)</td> </tr> <tr> <td><input type="checkbox"/> Cigarettes or cigarette butts</td> <td><input type="checkbox"/> Foam Rubber</td> <td><input type="checkbox"/> Soil</td> <td><input type="checkbox"/> Other: _____</td> </tr> </table>			<input type="checkbox"/> Ashes	<input type="checkbox"/> Clay	<input type="checkbox"/> Paint chips		<input type="checkbox"/> Carpet fibers	<input type="checkbox"/> Dust	<input type="checkbox"/> Paper	<input type="checkbox"/> Starch (laundry or cornstarch)	<input type="checkbox"/> Cigarettes or cigarette butts	<input type="checkbox"/> Foam Rubber	<input type="checkbox"/> Soil	<input type="checkbox"/> Other: _____						
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<p>4. On a typical day, how many times does your child eat fruit? ..... <input type="checkbox"/> 5 or more   <input type="checkbox"/> 4   <input type="checkbox"/> 3   <input type="checkbox"/> 2   <input type="checkbox"/> 1   <input type="checkbox"/> None</p>																				
<p>5. On a typical day, how many times does your child eat vegetables? ..... <input type="checkbox"/> 5 or more   <input type="checkbox"/> 4   <input type="checkbox"/> 3   <input type="checkbox"/> 2   <input type="checkbox"/> 1   <input type="checkbox"/> None</p>																				
<p>6. What <u>type</u> of milk does your child drink? (Select all that apply): <b>[425.1] [425.8]</b></p> <table style="width:100%; border: none;"> <tr> <td><input type="checkbox"/> Breastmilk</td> <td><input type="checkbox"/> Formula (name) _____</td> <td><input type="checkbox"/> Milk (Cow)</td> <td><input type="checkbox"/> Goat Milk</td> </tr> <tr> <td><input type="checkbox"/> Rice Milk or Almond Milk</td> <td><input type="checkbox"/> Soy Milk</td> <td><input type="checkbox"/> Lactose Free Milk</td> <td><input type="checkbox"/> None</td> </tr> <tr> <td></td> <td></td> <td></td> <td><input type="checkbox"/> Other: _____</td> </tr> </table> <p>What <u>kind</u> of milk does your child drink?   <input type="checkbox"/> Fat-free (skim)   <input type="checkbox"/> Low-fat (1%)   <input type="checkbox"/> Reduced fat (2%)   <input type="checkbox"/> Whole   <input type="checkbox"/> Not Applicable</p> <p>On a typical day, how many times does your child drink milk? .</p> <table style="width:100%; border: none;"> <tr> <td><input type="checkbox"/> 4 cups or more/Many times/day</td> <td><input type="checkbox"/> 3 cups/Three times/day</td> <td><input type="checkbox"/> 2 cups/ Twice/day</td> <td><input type="checkbox"/> 1 cup or less/Once/day or less</td> </tr> </table>			<input type="checkbox"/> Breastmilk	<input type="checkbox"/> Formula (name) _____	<input type="checkbox"/> Milk (Cow)	<input type="checkbox"/> Goat Milk	<input type="checkbox"/> Rice Milk or Almond Milk	<input type="checkbox"/> Soy Milk	<input type="checkbox"/> Lactose Free Milk	<input type="checkbox"/> None				<input type="checkbox"/> Other: _____	<input type="checkbox"/> 4 cups or more/Many times/day	<input type="checkbox"/> 3 cups/Three times/day	<input type="checkbox"/> 2 cups/ Twice/day	<input type="checkbox"/> 1 cup or less/Once/day or less		
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<p>7. On a typical day, how many times does your child drink juice, fruit/sports drinks, regular pop/soda, sweet tea and/or water with Kool- Aid or sugar? ..... <input type="checkbox"/> 4 or more   <input type="checkbox"/> 3   <input type="checkbox"/> 2   <input type="checkbox"/> 1   <input type="checkbox"/> None   <b>[425.2] [425.3]</b></p> <p>On a typical day, how many times does your child drink diet pop/soda and/or coffee/tea? ..... <input type="checkbox"/> 4 or more   <input type="checkbox"/> 3   <input type="checkbox"/> 2   <input type="checkbox"/> 1   <input type="checkbox"/> None</p> <p>On a typical day, how many times does your child drink plain water? ..... <input type="checkbox"/> 4 or more   <input type="checkbox"/> 3   <input type="checkbox"/> 2   <input type="checkbox"/> 1   <input type="checkbox"/> None</p>																				
<p>8. What is your child's water source? (Select all that apply): <b>[425.8]</b></p> <table style="width:100%; border: none;"> <tr> <td><input type="checkbox"/> City/County water system</td> <td><input type="checkbox"/> Rural water system</td> <td><input type="checkbox"/> Private well</td> <td><input type="checkbox"/> Bottled water</td> </tr> </table>			<input type="checkbox"/> City/County water system	<input type="checkbox"/> Rural water system	<input type="checkbox"/> Private well	<input type="checkbox"/> Bottled water														
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<p>9. Does your child drink any beverages, other than water from a baby bottle or sippy cup? ..... <input type="checkbox"/> Yes   <input type="checkbox"/> No   <b>[425.3]</b></p> <p>When does your child drink beverages, other than water from a bottle/sippy cup? (Select all that apply):</p> <table style="width:100%; border: none;"> <tr> <td><input type="checkbox"/> In bed at night</td> <td><input type="checkbox"/> At naptime</td> <td><input type="checkbox"/> At meals and snacks</td> <td><input type="checkbox"/> Carries a bottle/sippy cup around during the day</td> </tr> </table>			<input type="checkbox"/> In bed at night	<input type="checkbox"/> At naptime	<input type="checkbox"/> At meals and snacks	<input type="checkbox"/> Carries a bottle/sippy cup around during the day														
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<p>10. Does your child take any vitamins, minerals, herbs or herbal supplements? ..... <input type="checkbox"/> Yes   <input type="checkbox"/> No   <b>[425.7] [425.8]</b></p> <p>If yes, select all that apply:   <input type="checkbox"/> Children's multivitamin   <input type="checkbox"/> Iron supplement   <input type="checkbox"/> Fluoride supplement  <input type="checkbox"/> Herbal supplement   <input type="checkbox"/> Vitamin D   <input type="checkbox"/> Other: _____</p>																				
<p>11. On a typical day, how many hours is your child in front of a screen? (TV, computer, video game, cell phone) . . . . .</p> <table style="width:100%; border: none;"> <tr> <td><input type="checkbox"/> None</td> <td><input type="checkbox"/> less than 1 hour</td> <td><input type="checkbox"/> 1 hour</td> <td><input type="checkbox"/> 2 hours</td> <td><input type="checkbox"/> 3 hours</td> <td><input type="checkbox"/> 4 hours</td> <td><input type="checkbox"/> 5 or more hours</td> <td><input type="checkbox"/> Unknown</td> </tr> </table> <p>On a typical day, how many minutes does your child spend in active play/exercise? (breathing harder or sweating)</p> <table style="width:100%; border: none;"> <tr> <td><input type="checkbox"/> Less than 15 minutes</td> <td><input type="checkbox"/> 15 minutes</td> <td><input type="checkbox"/> 30 minutes</td> <td><input type="checkbox"/> 45 minutes</td> <td><input type="checkbox"/> 60 minutes (1 hour)</td> </tr> <tr> <td><input type="checkbox"/> 90 minutes (1½ hours) or more</td> <td><input type="checkbox"/> Not Applicable</td> <td></td> <td></td> <td></td> </tr> </table>			<input type="checkbox"/> None	<input type="checkbox"/> less than 1 hour	<input type="checkbox"/> 1 hour	<input type="checkbox"/> 2 hours	<input type="checkbox"/> 3 hours	<input type="checkbox"/> 4 hours	<input type="checkbox"/> 5 or more hours	<input type="checkbox"/> Unknown	<input type="checkbox"/> Less than 15 minutes	<input type="checkbox"/> 15 minutes	<input type="checkbox"/> 30 minutes	<input type="checkbox"/> 45 minutes	<input type="checkbox"/> 60 minutes (1 hour)	<input type="checkbox"/> 90 minutes (1½ hours) or more	<input type="checkbox"/> Not Applicable			
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<p>12. Has your child visited a dentist within the past 12 months? ..... <input type="checkbox"/> Yes   <input type="checkbox"/> No   <b>[425.8]</b></p> <p>Does your child have tooth decay (including baby bottle tooth decay), broken teeth, bleeding gums, missing teeth and/or misplaced teeth that make chewing difficult? ..... <input type="checkbox"/> Yes   <input type="checkbox"/> No</p> <p>Does your child brush their teeth with toothpaste that has fluoride? ..... <input type="checkbox"/> Yes   <input type="checkbox"/> No   <input type="checkbox"/> Don't know</p>																				

**Your CPA/Nutritionist will discuss your child's eating and activity habits and will ask more questions.**