

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 _____

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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
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15. Does your child eat fruit every day? Yes No
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16. Does your child eat vegetables every day? Yes No
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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 _____
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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
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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?
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Thank you!