



## Complete frontside ONLY

## **Child Health Assessment**

Date(s):	_ Child's Name:		
Parent/Guardian Name: _		Relationship:	
Child Health History	Questions (please complete	te all questions on this side – leave the backside blank)	
Where does your child go	for healthcare? Doctor/clini	ic name:	
Does your child attend we	ell visits?		
Is your child up to date or	n shots? Yes No	I don't know	
Does your child receive an	ny therapy or other services?	Physical Occupational Speech	
Home visiting:		Other:	_ N/A
Please list any medication	n(s) your child takes:		 □ n/a
_	_		
Does your child have:	Constipation Diarrhea	☐ Vomiting ☐ N/A	
Has anyone in your family	been tested for lead?	/es (levels): No I don't know	
Do you or your dentist ha	ve any dental concerns?	Yes No I don't have a	a dentist
Do you live in a temporary	y place (shelter, hotel, etc.)?	? Yes No	
Has your child entered for	ster care or moved foster car	re homes, within the past six months? Yes No	
Has your child been physi	cally, verbally, sexually abus	sed, or neglected? Yes No	
Do you worry about runni	ing out of food? Yes	] No	
Do you use local food ban	nks/pantries? Yes No	0	
What questions or concer	ns do you have about your o	child's health, eating habits, and breastfeeding?	

This portion is to be completed by WIC staff				
New Cert (date): Recert (date):	HA (date): Continue Goal			
Location of WIC Program Application:				
HT WT	Hgb (optional)			
Nutrition, Breastfeeding, and Physical Activity Questions (to be completed by WIC staff member)  Share with me the physical activities your child enjoys:				
Tell me about your experience with giving your child breast milk:				
Describe what your child eats and drinks each day:				
Targeted diet assessment may include:				
Vitamins, iron sources, enhancers, inhibitors	Self-feeding (progression and eating skills)			
• Dairy/calcium/vitamin D	Family meals/mealtimes			
Whole grains/fiber	Religious or cultural diets			
<ul> <li>Protein sources</li> </ul>	<ul> <li>Same foods as rest of the family</li> </ul>			
Fruits and vegetables	Bottle use/propped/sleep with bottle			
Sugar sweetened drinks/foods	What's in the bottle?			
<ul> <li>Foods limited/refused/avoided</li> </ul>	Open/sippy cup use			
<ul> <li>Meals away from home/fast food</li> </ul>	Water source			
Feeding tube	<ul> <li>Choking</li> </ul>			
Does your child eat unsafe foods or non-food items? Yes No Concerns:				
Check for unsafe foods:	Check for non-food items:			
Raw/undercooked meats	Paint chips, starch, coffee grounds			
<ul> <li>Uncooked deli and processed meats</li> </ul>	• Ice			
Unpasteurized foods	• Paper			
• Dirt/Clay				
Caregiver with limited feeding decision/inability to p				
Current/history of alcohol or substance abuse	Mental illness, including severe depression			
Intellectual disability Physical disability A	ge ≤ 17 years			
Notes:				