Department of Health
Women, Infants, and Children Program (WIC)

*Complete frontside ONLY*

# Child Health Assessment

**Date(s):** _____ **Child's Name:** _____

**Parent/Guardian Name:** _____ **Relationship:** _____

## Child Health History Questions *(please complete all questions on this side – leave the backside blank)*

**Where does your child go for healthcare? Doctor/clinic name:** _____

**Does your child attend well visits?** ☐ Yes ☐ No

**Is your child up to date on shots?** ☐ Yes ☐ No ☐ I don't know

**Does your child receive any therapy or other services?** ☐ Physical ☐ Occupational ☐ Speech

☐ Home visiting: _____ ☐ Other: _____ ☐ N/A

**Does your child have any medical conditions, or recent surgery, illness, food allergies, or injury?** Please describe:

_____

**Please list any medication(s) your child takes:** _____ ☐ N/A

**Is your child tube fed?** ☐ Yes, Please describe:_____ ☐ No

**Does your child have:** ☐ Constipation ☐ Diarrhea ☐ Vomiting ☐ N/A

**Has anyone in your family been tested for lead?** ☐ Yes (levels): _____ ☐ No ☐ I don't know

**Do you or your dentist have any dental concerns?** ☐ Yes _____ ☐ No ☐ I don't have a dentist

**Do you live in a temporary place (shelter, hotel, etc.)?** ☐ Yes ☐ No

**Has your child entered foster care or moved foster care homes, within the past six months?** ☐ Yes ☐ No

**Has your child been physically, verbally, sexually abused, or neglected?** ☐ Yes ☐ No

**Do you worry about running out of food?** ☐ Yes ☐ No

**Do you use local food banks/pantries?** ☐ Yes ☐ No

**What questions or concerns do you have about your 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 screen time and your child: Time/day _____** Days/week **_____**

**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
- Dairy/calcium/vitamin D
- Whole grains/fiber
- Protein sources
- Fruits and vegetables
- Sugar sweetened drinks/foods
- Foods limited/refused/avoided
- Meals away from home/fast food
- Feeding tube
- Self-feeding (progression and eating skills)
- Family meals/mealtimes
- Religious or cultural diets
- Same foods as rest of the family
- Bottle use/propped/sleep with bottle
- What's in the bottle?
- Open/sippy cup use
- Water source
- Choking

**Does your child eat unsafe foods or non-food items?** ☐ Yes ☐ No ☐ Concerns: _____

***Check for unsafe foods:***

- Raw/undercooked meats
- Uncooked deli and processed meats
- Unpasteurized foods

***Check for non-food items:***

- Paint chips, starch, coffee grounds
- Ice
- Paper
- Dirt/Clay

**Caregiver with limited feeding decision/inability to prepare foods:**

☐ Current/history of alcohol or substance abuse ☐ Mental illness, including severe depression

☐ Intellectual disability ☐ Physical disability ☐ Age ≤ 17 years ☐ N/A

**Notes:**