EARLY HEAD START

NUTRITION ASSESSMENT FOR INFANTS (BIRTH TO 11 MONTHS)

Child's Name: _____ D.O.B.: ____/____/____ Date Completed: ____/____/____

Answer the following questions to the best of your ability based on your baby's eating pattern and place a check mark in the box ☒ and/or write-in your answer.

CAREGIVER

1. How would you describe your baby's appetite? ☐ Good ☐ Fair ☐ Poor
2. Have you noticed any recent changes in your baby's appetite? ..... ☐ Yes ☐ No

   If yes, list changes: _____
3. Does your child have any allergies to certain foods? ..... ☐ Yes ☐ No

   If yes, please list: _____ (Staff forward this information to the Health Manager/kitchen staff)
4. Has the doctor ever told you that your baby has any medical conditions or illnesses? ..... ☐ Yes ☐ No

   If yes, list: _____
5. When was the last time your baby went to the doctor? Date:_____/_____/_____ ☐ Don't know
6. How would you describe feeding time with your baby? Check all that apply.

   ☐ Always pleasant ☐ Usually pleasant ☐ Sometimes pleasant ☐ Never pleasant
7. What types of things can your baby do? Check all that apply.

   ☐ Open mouth for breast or bottle ☐ Drink liquids ☐ Sit with support ☐ Bring objects to mouth and bite them

   ☐ Follow objects and sounds with eyes ☐ Put hand on mouth ☐ Drink from a cup that is held

   ☐ Hold bottle without support
8. How many wet diapers does your baby have in 24 hours? _____ wet/24 hours
9. How many dirty diapers does your baby have in 24 hours? _____ dirty/24 hours

PRIMARY FEEDING

10. What type of milk do you feed your baby? Check all that apply.

    ☐ Breast milk ☐ Iron-fortified formula ☐ Low-Iron formula ☐ Cow's milk (fat free/skim; 1%, 2%, whole)

    ☐ Rice or soy beverage ☐ Powdered milk ☐ Evaporated milk ☐ Sweetened condensed milk

    ☐ Goat's milk ☐ Don't know ☐ Other:_____
11. Are you currently breastfeeding your baby? ☐ Yes ☐ No
12. Did you ever breastfeed your baby? ..... ☐ Yes ☐ No

    If yes, how long? _____
13. How do you know when your baby is hungry? Check all that apply.

    ☐ Cries ☐ Small fussing sounds ☐ Sucking on hands or lips ☐ Turns head towards nipple or bottle

    ☐ Other: _____
14. How do you know when your baby is full? Check all that apply.

    ☐ Closes mouth ☐ Turns head away from nipple or bottle ☐ Pushes nipple out of mouth

    ☐ Shows interest in other things in the room ☐ Other: _____

BREASTFEEDING

(Complete this section only if fully or partially breastfeeding)

15. How is breastfeeding going?

☐ Good; I have the help I need. ☐ OK; I have some questions. ☐ Not so good; I need help.

16. How many times do you nurse, express or pump in 24 hours?

Nurse _____ times/24 hours Express _____ times/24 hours Pump _____ times/24 hours

17. Have you ever experienced sore nipples? ..... ☐ Yes ☐ No

18. Can you hear your baby swallowing during feedings? ..... ☐ Yes ☐ No

HANDLING EXPRESSED OR PUMPED BREAST MILK

19. How do you store your expressed breast milk? ☐ Freezer ☐ Refrigerator ☐ Other: _____

20. How long do you keep it in the refrigerator before you throw it away? _____ hours or days (circle one)

21. What do you do with breast milk left in the bottle?

☐ Leave it out to feed later ☐ Put it back into refrigerator for later ☐ Throw it away ☐ Other: _____

FORMULA (Complete only if baby is taking formula)

22. What kind of formula is your baby taking? Name: _____ ☐ Powder ☐ Liquid concentrate

☐ Ready to feed

23. How many ounces of formula does your baby take at a feeding? _____ ounces per feeding

And, how many feedings per day? _____ feedings/24 hours

HANDLING FORMULA

24. How much water and formula do you mix per feeding? ____ ounces of water with ____ ounces or ____scoops of formula

Are the scoops of formula level or heaping? ☐ Heaping ☐ Level

How do you store the formula after you mix it up? ☐ Refrigerator ☐ Other: _____

25. How long do you keep mixed formula in the refrigerator before you throw it away? _____ hours or days (Circle one)

26. How long do you let a bottle of formula sit at room temperature? _____ hours

27. What do you do with formula left in a bottle after a feeding?

☐ Leave it out to feed later ☐ Put it back in the refrigerator to feed later ☐ Throw it away ☐ Other: _____

WATER SUPPLY

28. What kind of water do you use for mixing formula or drinking for your baby? Check one.

☐ City or rural water system ☐ Private well ☐ Bottled water ☐ Nursery water

a. If private well, has it been tested for bacteria or nitrates? ..... ☐ Yes ☐ No ☐ Don't know

If yes, check results: ☐ Safe ☐ Unsafe ☐ Don't know

b. Do you know if your water if fluoridated? ☐ Yes ☐ No ☐ Don't know

SOLID FOODS & JUICES

29. Has your baby started on infant cereal, baby food or table food? ..... ☐ Yes ☐ No

If yes, at what age did you start feeding these foods and what foods?

Are they mostly: ☐ Mashed ☐ Pureed or Baby foods ☐ Chopped ☐ Liquid ☐ Finger foods

☐ Other: _____

If yes, how do you feed these foods? ☐ Spoon ☐ Bottle/infant feeder ☐ Baby feeds self

30. Does your baby eat honey or any foods made with honey such as honey graham crackers, muffins,et ☐ Yes ☐ No

31. Does your baby drink 100% fruit juice? ..... ☐ Yes ☐ No

If yes, how many ounces of full strength juices in a day? _____ ounces per day

32. How do you feed juice to your baby? ☐ Bottle ☐ Cup

33. At what age did you begin feeding juice to your baby? _____ months

34. Does your baby eat foods such as:

a. unpasteurized fruit or vegetable juices or dairy products ..... ☐ Yes ☐ No

b. soft cheeses such as Feta, Brie, Camembert, blue-veined cheese, Mexican style cheese(queso) ☐ Yes ☐ No

c. raw or undercooked meats, fish, chicken, turkey, or eggs ..... ☐ Yes ☐ No

d. raw vegetable sprouts such as alfalfa, clover, and radish ..... ☐ Yes ☐ No

e. undercooked or raw tofu ..... ☐ Yes ☐ No

f. uncooked luncheon meats, deli meats, hot dogs ..... ☐ Yes ☐ No

35. Is your baby on a special diet? ..... ☐ Yes ☐ No

If yes, check or write-in what kind: ☐ Vegan ☐ Macrobiotic ☐ Other: _____

36. Does your baby routinely eat sweet foods like lollipops, candy, sweetened cereals, or desserts? ..... ☐ Yes ☐ No

Items(s) & Amount(s): _____

BABY BOTTLES & SIPPY CUPS

37. Does your baby drink anything other than breast milk or formula in a baby bottle or sippy cup? .....☐ Yes ☐ No

If yes, check all that apply: ☐ Milk ☐ Juice (100%) ☐ Water ☐ Soft drinks/soda/pop

☐ Gelatin water/Kool-Aid ☐ Sweetened tea ☐ Other: _____

38. Do you dip your baby's pacifier in Karo/corn syrup or honey or add it to your baby's bottle? ..... … ☐ Yes ☐ No

39. Does your baby take a bottle to bed at night or naptime? ..... ☐ Yes ☐ No

40. Do you hold your baby's bottle while feeding him/her? ..... ☐ Yes ☐ No

41. Does your baby carry a bottle or sippy cup around? ..... ☐ Yes ☐ No

SUPPLEMENTS

42. Have you given your child any vitamins, minerals, herbs, or herbal supplements in the past month or currently?

☐ Yes ☐ No If yes, check all that apply. ☐ Infant multi vitamin ☐ Vitamin D Supplement

☐ Herbal supplement, remedies or teas ☐ Iron supplement ☐ Fluoride supplement

☐ Other: _____

FOOD SECURITY AND PROGRAM PARTICIPATION

43. In the past month, did you or anyone in your household ever eat less than you felt you/they should or not eat for a whole day because there wasn't enough money for food? ☐ Yes ☐ No ☐ Don't know or refused

44. In the past month, if you ran out of formula what did you do? List: _____

45. Does your baby or family participate in any of the following programs? ..... ☐ Yes ☐ No

If yes, which ones. ☐ Food Stamps ☐ Family Nutrition Education Program (FNEP) ☐ Commodity Program

☐ Food Pantry ☐ WIC (location) ☐ Other: _____

46. Do you have adequate equipment for food storage and preparation such as a refrigerator, a stove that works, and storage free from pests and harmful chemicals? ..... ☐ Yes ☐ No

_____ _____

Patient/Guardian Signature Date Staff Signature: Date

AGENCY USE ONLY Reviewed by: _____ Date: _____

Discuss all areas marked with the parent/guardian to determine what type of referral is needed.

Disposition: NO Concerns Refer WIC Refer to Nutrition Consultant Refer to physician

Refer to dentist Refer to other services/parent training, Specify:_____

HEAD START RAPIDES

NUTRITION ASSESSMENT FOR 0 – 11 MONTHS

Performance Standards 1304.23 (a) (1) (2)

This form is completed upon enrollment in its entirety with no blanks and filed in the child's health file.