

**NUTRITION ASSESSMENT FOR 1-5 YRS OLD**

Child's Name: \_\_\_\_\_ D.O.B.: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date Completed: \_\_\_\_/\_\_\_\_/\_\_\_\_

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

**CAREGIVER**

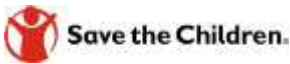
- How would you describe your child's appetite?  Good  Fair  Poor
- Have you noticed any recent changes in your child's appetite?.....  Yes  No  
If yes, list changes: \_\_\_\_\_
- Do you have any questions about your child's eating habits? .....  Yes  No  
If yes, what are they: \_\_\_\_\_
- What do you do when your child does not want to eat or only wants to eat a certain kind of food?  
\_\_\_\_\_
- Does your child frequently choke or gag on food? .....  Yes  No  
If yes, list: \_\_\_\_\_
- How are most foods your child eats prepared? Check all that apply.  
 Mashed  Pureed or Child foods  Chopped  Liquid  Finger foods
- Does your child have any allergies to certain foods? .....  Yes  No  
If yes, please list: \_\_\_\_\_(Notify Health Manager and give parent an Individual Health Plan)

**MEAL PATTERN**

- How many times a day does your child eat? \_\_\_\_\_meals/day \_\_\_\_\_snacks/day What type of foods does your child typically snack on? Check all that apply.  
 Milk, yogurt, cheese  Meat, fish, eggs, beans  Fruits or vegetables  Bread, cereal, rice and pasta  
 Chips/salty foods  Cookies/cakes/sweets  Goat's milk  Don't know
- How many days in a week does your family eat a meal together? \_\_\_\_\_meals/day
- At meal time, how often does your child eat the same foods as the rest of the family? (Check one)  
 Most of the time  Sometimes  Rarely If rarely, what does your child eat? List: \_\_\_\_\_
- How many days a week does your child eat at a child care setting (including Head Start)? \_\_\_\_\_days/week
- In a typical week, how many meals do you eat from a restaurant including fast food? \_\_\_\_\_meals/week
- In a day, how many meals or snacks are eaten in front of the TV? \_\_\_\_\_snacks/day \_\_\_\_\_meals/day

**EATING PATTERN**

- How are most foods prepared? Check all that apply.  
 Baked  Fried  Boiled  Roasted  Broiled  Grilled  Microwaved
- Are there any foods that you think your child isn't eating enough of?  Yes  No



If yes, check all that apply.  Milk, yogurt, cheese  Meat, fish, eggs, beans  Fruits  Vegetables  Bread, cereal, rice and pasta

16. Are there any foods that you think your child is eating too much of? .....  Yes  No

If yes, list: \_\_\_\_\_

17. Does your child routinely eat sweet foods like lollipops, candy, sweetened cereals, or desserts? .....  Yes  No

Items(s) & Amount(s): \_\_\_\_\_

18. Does your child eat foods such as:

a. unpasteurized fruit or vegetable juices .....  Yes  No

b. unpasteurized dairy products .....  Yes  No

c. soft cheeses such as Feta, Brie, Camembert, blue-veined cheese, Mexican style cheese  Yes  No

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

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

f. undercooked or raw tofu .....  Yes  No

19. Does your child routinely eat things that are non-food items? .....  Yes  No

If yes, check all that apply.  Ashes  Clay  Paint Chips  Carpet fibers  Dust  Soil  Paper

Cigarettes or cigarette butts  Foam rubber  Starch (laundry or cornstarch)  Other: \_\_\_\_\_

20. Does your child feed himself/herself? .....  Yes  No

If yes, check all that apply.  Eats with fingers  Uses a fork/spoon  Drinks from a sippy cup

Drinks from a regular cup or glass  Other: \_\_\_\_\_

21. Is your child on a special diet? .....  Yes  No

If yes, check:  Vegetarian  Vegan  Food allergy or intolerance  Low calorie/weight loss

Macrobiotic  Other: \_\_\_\_\_ (Notify Health Manager)

22. Are you breastfeeding this child? .....  Yes  No

If yes, how often? \_\_\_\_\_

**BEVERAGES**

23. Does your child drink milk? .....  Yes  No

If yes, check all that apply.  Formula \_\_\_\_\_  Fat-free (skim)  Low-fat (1%)

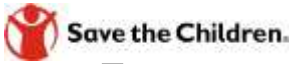
Reduced-fat (2%)  Whole  Rice or Soy fortified  Powdered

Evaporated  Goat's milk  Sweetened condensed  Other: \_\_\_\_\_

24. How often does your child drink milk? (Check one)

Many times/day (More than 3 cups)  Several times/day (3 cups)  Once/day (1 cup)  Less than once/day

25. What other beverages does your child drink in a typical day? Check all that apply.



- Juice 100%     Water - plain     Fruit drinks     Sports drinks     Regular pop/soda
- Diet pop/soda     Coffee/tea     Gelatin water/Kool-Aid
- Other: \_\_\_\_\_

26. How often does your child drink 100% fruit juice? (Check one)

- Many times/day (More than 3 cups)     Several times/day (3 cups)     Once/day (1 cup)     Less than once/day

27. What is your child's main source of water? (Check one)

- City water system     Rural water system     Private well     Bottled 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 is fluoridated?     Yes     No     Don't know

**BABY BOTTLES & SIPPY CUPS**

28. Does your child drink from a baby bottle? .....  Yes     No

29. What is usually fed in the bottle?

- Milk     Juice (100%)     Water     Fruit drinks     Sports drinks     Soda/pop
- Coffee/ tea     Cereal/other solid foods added to the bottle     Other: \_\_\_\_\_

30. Does your child take the bottle or sippy cup to bed at night or naptime     Yes     No

31. Does your child carry a bottle or sippy cup around? .....  Yes     No

**SUPPLEMENTS**

32. Does your child take any vitamins, minerals, herbs, or herbal supplements? .....  Yes     No

- If yes, check all that apply.
- Children's multi-vitamin     Iron supplement     Fluoride supplement
  - Herbal supplement     Other: \_\_\_\_\_

**FOOD SECURITY AND PROGRAM PARTICIPATION**

33. 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

34. Does your family participate in any food or nutrition programs? .....  Yes     No

- If yes, check all that apply.
- Food stamps     WIC (location \_\_\_\_\_)     School Lunch
  - Family Nutrition     Commodity Program     Education Program (FNEP)     Other: \_\_\_\_\_

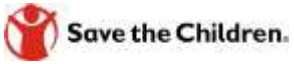
35. Do you have adequate equipment for food storage and preparation such as a refrigerator, a stove that works, and storage free from pests and harmful chemicals? .....  Yes     No

**PHYSICAL ACTIVITY**

36. In a typical day, how many hours does your child watch TV, play video games, and/or play computer games?

- Less than 1 hour     1-2 hours     More than 2 hours

37. In a typical day, how many hours does your child play outside?     Less than 1 hour     1-2 hours     More than 2 hours



\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Staff Signature

\_\_\_\_\_  
Date

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**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 to WIC Refer to Nutrition Consultant Refer to Physician Refer to dentist  
Refer to other services/parent training, Specify: \_\_\_\_\_

## NUTRITION ASSESSMENT FOR 1 – 5 YEARS OLD

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

All EHS (starting at 12 months) and HS children will complete the Nutrition Assessment 1 – 5 Yrs. Old upon enrollment. This form must be completed in its entirety with no blanks, is filed in the child's health file and updated annually. Rev.: 10/1/14