|  |  |  |
| --- | --- | --- |
| **Health** | | |
| **1. \*Does your child have access to medical care?** |  Yes |  No |
| **2. \*Does your child have any health or medical conditions? If Yes, select all that apply: (*See Ref 13*)** |  Yes |  No |
| **2a. \*Does the condition affect your child’s nutrition or**  **eating?** |  Yes |  No |
| **3. \*Does your child have any problems with their teeth**  **or gums?** |  Yes |  No |
| **4. \*Does your child have a dentist?** |  Yes |  No |
| **5. \*Does anyone living in your household smoke**  **tobacco or marijuana inside your home or car?** |  Yes |  No |
| **6. \*In the past 6 months, has your child been threatened or physically hurt in any way by any**  **members of your household?** |  Yes |  No |
| **7. \*In the past 12 months, have you ever worried whether your food would run out before you got money to buy more?** | * Often true * Sometimes true * Never True * Don’t know or Refused | |
| **8. \*In the past 12 months, have you ever run out of food that you bought, and did not have money to buy more?** |  Yes |  No |
| **9. \*Are you worried that you may not have housing in**  **the next 2 months?** |  Yes |  No |

|  |  |
| --- | --- |
| **Nutrition** | |
| **1. \*Which of the following best describes your child’s eating?** | * Good * Will only eat limited number of foods * Eats too much * Doesn’t eat enough |
| **2. \*How does your child feed herself/himself?** | * By self * By self with some assistance using fork/spoon * By self with fingers * No self-feeding |
| **3. \*Does your child have any food allergies?** |  Yes  No |
| *If yes, select all that apply:*   * Milk * Soy * Eggs * Nuts * Peanuts | * Shellfish * Fish * Wheat * Corn * Other (Enter Note) |
| **4. \*Does your child follow a special diet or limit certain foods?** |  Yes  No |
| *If yes, select all that apply:*   * Diabetic * High Calorie * Low Calorie | * Vegan * Vegetarian * High protein, low carb |

|  |  |  |  |
| --- | --- | --- | --- |
| * Low Lactose * Gluten Free |  | * Other (Enter Note): * Pureed foods only | |
| **5. How often does your child eat from the following food groups?** | | | |
| a. **\***Fruit |  Most days |  Some days |  Rarely/never |
| b. **\***Vegetables |  Most days |  Some days |  Rarely/never |
| c. **\***Whole Grains |  Most days |  Some days |  Rarely/never |
| d. **\***Milk / Dairy Foods |  Most days |  Some days |  Rarely/never |
| e. **\***Protein Foods |  Most days |  Some days |  Rarely/never |
| f. **\***Desserts / Sweets |  Most days |  Some days |  Rarely/never |
| g. **\***Junk Foods |  Most days |  Some days |  Rarely/never |
| **6. \*Do you give your child any of the following:** | | | |
| * Cold deli meat * Cold hot dogs * Soft unpasteurized cheese |  | * Raw vegetable sprouts * Raw/uncooked meat or chicken; raw eggs * None of these | |
| **7. \*Does your child eat any non-food items (dirt, sand, paint chips)?** | |  Yes  No | |
| **8. \*What does your child drink on most days?** | | | |
| * Water   Type of Water:  tap  bottled   * Cow’s Milk   Type of Milk:  whole  2%  1%  nonfat   * Soy * Non-dairy Beverage (Rice, Nut, etc.) * 100% Juice * Tea | | * Soda * Other Sugar Sweetened Drinks * PediaSure * Toddler Formula * Other (Enter Note) | |
| **9. \*What does your child drink from?** | | * Bottle * Sippy Cup * Cup without lid | |
| **10. \*What do you do if your child does not finish his/her food at mealtimes?** | | * Nothing / let child decide if they are full * Save food for later * Try hard to get child to eat * Give a different or preferred food * Offer reward | |
| **11. \*Do you give your child a multi-vitamin daily?** | |  Yes  No | |
| **12. \*Do you give your child any herbs, other vitamin/mineral supplements or home remedies?** | |  Yes  No | |
| **13. \*How many hours a day does your child have screen**  **time, such as TV, computer, cell phone, tablet, video games?** | | * Less than 2 hours * More than 2 hours | |