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| **Health** |
| 1. **\*Does your baby have access to medical care?**
 | 🞏 Yes 🞏 No |
| 1. **\*What was your baby’s due date?**
 | \_\_\_ / \_\_\_ / \_\_\_\_\_\_ |
| 1. **\*Does your baby have any health or medical conditions? If Yes, select all that apply: (*See Ref 13*)**
 | 🞏 Yes 🞏 No\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **3a. Does the condition affect your baby’s nutrition or eating?** | 🞏 Yes 🞏 No |
| 1. **\*Does your baby have any problems with their teeth or gums?**
 | 🞏 Yes 🞏 No |
| 1. **\*Does your baby have a dentist?**
 | 🞏 Yes 🞏 No |
| 1. **\*Does anyone living in your household smoke tobacco or marijuana *inside* your home or car?**
 | 🞏 Yes 🞏 No |
| 1. **\*Since birth, has your baby been threatened or physically hurt in any way by any members of your household?**
 | 🞏 Yes 🞏 No |
| 1. **\*Within the past 12 months you worried whether your food would run out before you got money to buy more.**
 | 🞏 Often True🞏 Sometimes True🞏 Never True🞏 Don’t Know or Refuse |
| 1. **\*Within the past 12 months the food you bought just didn’t last and you didn’t have money to get more.**
 | 🞏 Often True🞏 Sometimes True🞏 Never True🞏 Don’t Know or Refuse |
| 1. **\*Are you worried that you may not have housing in the next 2 months?**
 | 🞏 Yes 🞏 No |

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| **Nutrition – 0-3 Months (IBF, IBP)** |
| 1. **\*Do you give your baby any of these?**
 | 🞏 Vitamin Drops🞏 Vitamin D🞏 Fluoride🞏 Iron🞏 None |
| ***If feeding formula and breastmilk:*** |
| 1. **\*Describe how you mix the formula?**

**\*Which do you put in the bottle first?** | \_\_\_\_\_\_ ounces water with \_\_\_\_\_\_ scoops /ounces formula🞏 Formula 🞏 Water |
| 1. **\*Describe how you feed your baby the bottle?**
 | 🞏 Held by parent or other caregiver🞏 Bottle propped in crib/car seat/stroller🞏 Paced Bottle Feeding |
| **Baby Behavior** |
| 1. **\*In 24 hours, what is the longest stretch of time that your baby sleeps?**
 | \_\_\_\_\_\_ hours |
| 1. **\*What questions do you have about your baby’s sleep?**
 |  |
| 1. **\*How does your baby show you he or she is hungry?**
 | 🞏 Hands near mouth🞏 Bends arms and legs🞏 Sucking noises🞏 Puckers lips🞏 Searches for nipple (rooting)🞏 Cries [late sign] |
| 1. **\*How does your baby show you he or she is full?**
 | 🞏 Sucks slower or stops sucking🞏 Relaxes hands and arms🞏 Turns away from nipple🞏 Pushes away🞏 Falls asleep |
| 1. **\*Does it seem like your baby is crying too much?**
 | 🞏 Yes 🞏 No |
| 1. **\*Is it ever hard to figure out what your baby needs?**
 | 🞏 Yes 🞏 No |

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| **Nutrition – 4-11 Months (IBF, IBP)** |
| 1. **\*How is feeding going?**
 | 🞏 Great🞏 Not so well🞏 Mostly Ok |
| 1. **\*How does your baby show you he/she is hungry?**
 | 🞏 Hands near mouth🞏 Bends arms and legs🞏 Sucking noises🞏 Puckers lips🞏 Searches for nipple (rooting)🞏 Cries [late sign] |
| 1. **\*How does your baby show you he or she is full?**
 | 🞏 Sucks slower or stops sucking🞏 Relaxes hands and arms🞏 Turns away from nipple🞏 Pushes away🞏 Falls asleep |
| 1. **\*Describe how you mix the formula?**

**\*Which do you put in the bottle first?** | \_\_\_\_\_\_ ounces water with \_\_\_\_\_\_ scoops /ounces formula🞏 Formula 🞏 Water |
| 1. **\*What does your baby drink besides breastmilk or formula?**
 | 🞏 Nothing else🞏 Water🞏 Milk (cow, goat, sheep, nut, soy)🞏 Juice🞏 Sugar water🞏 Pedialyte🞏 Cereal in bottle🞏 Tea🞏 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. **\*Do you give your baby any of these?**
 | 🞏 Vitamin Drops🞏 Vitamin D🞏 Fluoride🞏 Iron🞏 None |
| 1. **\*Does your baby use**
 | 🞏 Cup with lid🞏 Cup without lid🞏 Does Not Use a Cup |
| 1. **\*How often do you offer your baby solid foods?**
 | 🞏 Not at all🞏 1-2 times per day🞏 3 or more times per day |
| 1. **\*What are the solid foods you offer**
 | 🞏 Baby Cereal🞏 Jarred baby foods🞏 Table food |
| 1. **\*What textures of foods does your baby eat?**
 | 🞏 None🞏 Mashed🞏 Soft pieces🞏 Smooth🞏 Chopped |
| 1. **\*Does your baby often have constipation or diarrhea?**
 | 🞏 Yes 🞏 No |

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| **Nutrition – 0-3 Months (INB)** |
| 1. **\*How is feeding going?**
 | 🞏 Not Good🞏 Great🞏 Ok |
| 1. **\*What is baby fed other than formula?**
 | 🞏 Nothing else🞏 Cereal in bottle🞏 Sugar water🞏 Milk (cow, goat, sheep, nut, soy)🞏 Baby foods🞏 Juice🞏 Water🞏 Tea🞏 Pedialyte🞏 Table Foods🞏 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. **\*Do you give your baby any of these?**
 | 🞏 Vitamin Drops🞏 Vitamin D🞏 Fluoride🞏 Iron🞏 None |
| 1. **\*How long does it take to feed your baby?**
 | \_\_\_\_\_\_ minutes |
| 1. **\*Describe how you mix the formula**

**\*Which do you put in the bottle first?** | \_\_\_\_\_\_ ounces water with \_\_\_\_\_\_ scoops /ounces formula🞏 Formula 🞏 Water |
| 1. **\*Describe how you feed your baby the bottle?**
 | 🞏 Held by parent or other caregiver🞏 Bottle propped in crib/car seat/stroller🞏 Paced Bottle Feeding |
| 1. **\*Does your baby often have constipation or diarrhea?**
 | 🞏 Yes 🞏 No |
| **Baby Behavior** |
| 1. **\*In 24 hours, what is the longest stretch of time that your baby sleeps?**
 | \_\_\_\_\_\_ hours |
| 1. **\*What questions do you have about your baby’s sleep?**
 |  |
| 1. **\*How does your baby show you he or she is hungry?**
 | 🞏 Hands near mouth🞏 Bends arms and legs🞏 Sucking noises🞏 Puckers lips🞏 Searches for nipple (rooting)🞏 Cries [late sign] |
| 1. **\*How does your baby show you he or she is full?**
 | 🞏 Sucks slower or stops sucking🞏 Relaxes hands and arms🞏 Turns away from nipple🞏 Pushes away🞏 Falls asleep |
| 1. **\*Does it seem like your baby is crying too much?**
 | 🞏 Yes 🞏 No |
| 1. **\*Is it ever hard to figure out what your baby needs?**
 | 🞏 Yes 🞏 No |

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| **Nutrition – 4-11 Months (INB)** |
| 1. **\*How is feeding going?**
 | 🞏 Great🞏 Not so well🞏 Mostly Ok |
| 1. **\*How does your baby show you he/she is hungry?**
 | 🞏 Hands near mouth🞏 Bends arms and legs🞏 Sucking noises🞏 Puckers lips🞏 Searches for nipple (rooting)🞏 Cries [late sign] |
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| 1. **\*What does your baby drink besides breastmilk or formula?**
 | 🞏 Nothing else🞏 Water🞏 Milk (cow, goat, sheep, nut, soy)🞏 Juice🞏 Sugar water🞏 Pedialyte🞏 Cereal in bottle🞏 Tea🞏 Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| 1. **\*Do you give your baby any of these?**
 | 🞏 Vitamin Drops🞏 Vitamin D🞏 Fluoride🞏 Iron🞏 None |
| 1. **\*Does your baby use**
 | 🞏 Cup with lid🞏 Cup without lid🞏 Does Not Use a Cup |
| 1. **\*How often do you offer your baby solid foods?**
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| 1. **\*Does your baby often have constipation or diarrhea?**
 | 🞏 Yes 🞏 No |