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| **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 |

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| **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
 |