

Nutrition & Activity Self-History Form - Child 1-5 years

To be completed at all WIC visits by the parent or guardian with children ages 1 to 5 years.

Please complete the questions below about yourself and your child or children who are 1 to 5 years old.

Sex (circle): Male Female **Age:** ____years ____months **Birth Weight** (for child 12-23 months) _____ (141)

Medical Information:

- Does your child have any medical problems today? ____ Cold ____ Rashes (353) ____ Wheezing/Asthma (360)
____ Diarrhea ____ Constipation Other: _____
- What items do you give your child/children (circle all that apply)? Vitamins (425.7) Fluoride (425.8)
Iron Medicines (please write in his/her medicines): _____ (357)
- Does your child have any food allergies? Yes (353) No
If yes, please write in his/her food allergies: _____ (355)
- Does anyone in your house smoke cigarettes or use other tobacco products? Yes (904) No
- Has your 2-5 year old child been to the dentist? (381, 425.2, 425.3) Yes No
- Has your child been to see the doctor recently? Yes No Appointment Made Yet No insurance
If yes, please write in your doctor's name: _____

Family History: Do any of your family members have any of the following health conditions?:

<u>Health Condition:</u>	<u>Circle the family member(s) with the health condition:</u> (114)					
Diabetes	Mother	Father	Grandparent	Aunt	Uncle	None/Unknown
Heart Disease / Heart Attack	Mother	Father	Grandparent	Aunt	Uncle	None/Unknown
High Blood Pressure	Mother	Father	Grandparent	Aunt	Uncle	None/Unknown
Obesity	Mother	Father	Grandparent	Aunt	Uncle	None/Unknown
Stroke	Mother	Father	Grandparent	Aunt	Uncle	None/Unknown

Please circle the answers to the questions below:

- Food Choices** - how many **times per day** does your child / children: (425.1 & .2)
 - Eat vegetables (not French fries)? 0-1 times/day 2-3 times/day 4-5 times/day 6-7 times/day
 - Eat fruit? 0-1 times/day 2-3 times/day 4-5 times/day 6-7 times/day
 - Eat fried food? 0-1 times/day 2-3 times/day 4-5 times/day 6-7 times/day
 - Eat sweets and/or salty snacks? 0-1 times/day 2-3 times/day 4-5 times/day 6-7 times/day
(such as chips, candy, cookies)
 - Drink water? 0-1 times/day 2-3 times/day 4-5 times/day 6-7 times/day
 - Drink soda or sweetened drinks? 0-1 times/day 2-3 times/day 4-5 times/day 6-7 times/day
 - Drink WIC 100% juice? 0-1 times/day 2-3 times/day 4-5 times/day 6-7 times/day
 - Circle what type of milk your child /children drink most often:
Whole 2% 1% Non-fat/Skim Soy Formula Breastmilk Low lactose
Other types of milk (chocolate, etc.) Rarely drinks milk Never drinks milk (355)
- Meal Patterns** – how many **days per week** does your child / children:
 - Eat breakfast? 0-1 days/wk 2-3 days/wk 4-5 days/wk 6-7 days/wk
 - Eat a meal with the family? 0-1 days/wk 2-3 days/wk 4-5 days/wk 6-7 days/wk
 - Eat food from a fast food restaurant? 0-1 days/wk 2-3 days/wk 4-5 days/wk 6-7 days/wk
 - Eat meals or snacks in front of the TV? 0-1 days/wk 2-3 days/wk 4-5 days/wk 6-7 days/wk
- Nutrition Habits:**
 - What things, other than food, does your child/children eat? (circle all that apply) Dirt Clay Crayons

Dust Ashes Cigarette Butts Paint Chips Foam Rubber Other: _____ (425.9)

3. Nutrition Habits (continued):

b. Which of these does your child/children use now to eat or drink? (circle all that apply) (425.3, 425.4)

Breast Bottle Cup (no top) Sippy Cup Spoon Fork Fingers

c. How would you describe your child/children's eating?

OK Picky Eats too much Eats too little Won't try new things

Other eating habits: _____

d. I make sure my child/children eat(s) meals and snacks about the same times every day.

Usually Sometimes Not very often No snacks between meals

e. I make my child/children taste everything I make for a meal.

Usually Sometimes Not very often

f. To get my child/children to eat, I offer something like a dessert or a toy.

Usually Sometimes Not very often

g. My child/children eat(s) off and on all day.

Usually Sometimes Not very often

h. If I don't set limits, my child/children eat(s) too much.

Usually Sometimes Not very often

4. Physical Activity

If child is 12-23 months, answer question below and skip to question #3.

1. What types of activity does your child do? (circle all that apply)

Walking Running Hopping Skipping Jumping Throwing Balls
Imitates what other people do Scribble with a crayon Reads books with parent Talks and sings with parent

2. How many **days per week** does your child/children: (applies to children 2-5 years of age)

a. Participate in "free" play or unstructured play time with other kids?

0-1 days/wk 2-3 days/wk 4-5 days/wk 6-7 days/wk

b. Participate in play groups, team sports or other structured physical activity with the family or other kids?

0-1 days/wk 2-3 days/wk 4-5 days/wk 6-7 days/wk

3. How many **hours per day** does your child/children:

a. Watch TV? Less than 1 hours/day 1-2 hours 3-4 hours 5 or more hours

b. Use computer and play video games?

Less than 1 hours/day 1-2 hours 3-4 hours 5 or more hours

c. Do any of your children have a TV in their bedroom? Yes No

d. Do you allow your child/children to eat in the bedroom with the TV on? Yes No

e. Do you monitor the TV shows your child/children watch? Yes No

f. Does your child go to sleep and wake up at about the same time each day? Yes No

5. Concerns:

Are you concerned about your weight? (114) Yes No

Do you feel you are: underweight a healthy weight overweight

Are you concerned about the weight of any of your children? Yes No

Do you feel your 2-5 year child is: underweight a healthy weight overweight

Are you concerned about the eating habits of any of your children? Yes No

Are you concerned about the activity levels of any of your children? Yes No

Do you often run out of money or food stamps to buy food? Yes No Sometimes

Do you have other concerns you would like to discuss today? Yes No

Please write other concerns here: _____

Thank you for answering these questions. Please return the completed form to the WIC clerk.