

Nutrition & Activity Self-History Form: Infant Midpoint

To be completed at all WIC visits by the parent or guardian with infants' ages 6-12 months.

Please complete the questions below about your child.

Sex (circle): Male Female

Age: _____ months

Birth Weight: _____ pounds _____ ounces

Number of Weeks Pregnant at Birth: _____

Medical Information:

1. Does your baby have any medical problems today? Cold Rashes Excessive Spit Up
 Diarrhea Constipation Other: _____
2. What items do you give your baby (circle all that apply)? Vitamins Fluoride Iron
Medicines (please write in his/her medicines): _____
3. Does your baby have any food allergies? Yes No
If yes, please write in his/her food allergies: _____
4. When was your baby's last doctor's appointment? Date: _____
What did you go to the doctor for? _____
Doctor's name: _____
5. Do you "brush" your baby's gums/teeth? Yes No

Please check the answers to the questions below:

1. Feeding -

Please answer the questions below based on your baby's feeding method. If your baby takes breast milk and formula, answer all the questions.

a. How many times in a 24 hour period do you feed your baby:

- a. Formula? _____
- b. Breast Milk? _____
- c. Food? _____

<input type="checkbox"/> Breastfeeding	<input type="checkbox"/> Formula, type: _____
Do you feel breastfeeding is going well for you and your baby so far? <input type="checkbox"/> Yes <input type="checkbox"/> No	How many ounces do you give at each feeding? _____
Does your baby seem satisfied after nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No	How many ounces of formula do you make at a time? _____

- b. If you have leftover breast milk/formula in a bottle what do you do with it? _____
- b. Do you feel that your baby is accepting the breast milk/formula well? Yes No
If no, please explain: _____
- c. Are you feeding your baby anything other than breast milk or formula? Yes No
Please list other foods your baby has tried: _____

- d. Which of the following do you give your baby? (circle all that apply)
 Water Juice Soda Gatorade Milk (Cow or Goat) Other

2. Meal Patterns –

- b. When providing breast milk or formula in a bottle, where do you most often have him/her? (Check all that apply)
- Cradled in my lap In his/her car seat In a high Chair Laying down on a blanket

3. Nutrition Habits :

- a. Which of these do you let your baby use when feeding? (circle all that apply)

Bottle Cup (no top) Sippy Cup Spoon Fingers

- a. I feel comfortable allowing my baby to try feeding him/herself some foods.

Often Usually Sometimes Not very often

- b. What drinks are offered in a bottle besides breast milk or formula? _____

- c. How would you describe your baby's eating?

OK Picky Eats too much Eats too little

- d. I make sure my baby eats a certain amount at each feeding.

Often Usually Sometimes Not very often

- e. Do you ever put your baby to bed with a bottle? Yes No Only water

4. Development

- a. Do you place your baby in different positions to help them learn things like rolling, creeping, crawling?

Often Usually Sometimes Not very often

- b. Do you talk and sing to your baby?

Often Usually Sometimes Not very often

- c. Do you offer your baby objects to reach for?

Often Usually Sometimes Not very often

- d. Do you create routines for your baby?

Often Usually Sometimes Not very often

5. Concerns: Are you concerned about your weight?

Yes No

Are you concerned about the weight of any of your children?

Yes No

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 have other concerns you would like to discuss today?

Yes No

Do you often run out of money or food stamps to buy food?

Yes No Sometimes

Please write other concerns here: _____

STOP HERE. Thank you for answering these questions. Please return the completed form to the WIC staff.