**Nutrition Screening Questionnaire**

**Child Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Age** \_\_\_\_\_\_\_ **Birth date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **M F**

**Your name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Relationship to child** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Premature? Yes (2) No If yes, number of weeks \_\_\_\_ Birth weight \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**The following questions will help us learn more about your child. Please answer each of the following questions**.

How does your child appear to you?

\_\_\_\_\_ overweight (3) \_\_\_\_\_ underweight (4) \_\_\_\_\_ just right \_\_\_\_\_ short (2)

Do any of the following apply to your child's food intake? Check all that apply Yes (3) No

\_\_\_\_\_ refuses many foods \_\_\_\_\_ drinks more than 40 oz. milk per day \_\_\_\_\_ eats too much

\_\_\_\_\_ refuses solid foods \_\_\_\_\_ has a poor appetite \_\_\_\_\_ eats too little

\_\_\_\_\_ eats fewer than 3 times a day other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child have any feeding or eating problems? No Yes (4) check any that apply

\_\_\_\_\_ difficulty sucking \_\_\_\_\_ difficulty feeding self \_\_\_\_\_ chokes on solids

\_\_\_\_\_ difficulty chewing foods \_\_\_\_\_ chokes on liquids \_\_\_\_\_ loses food from mouth

\_\_\_\_\_ using bottle after age 2 years \_\_\_\_\_ difficulty drinking from cup other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child have a feeding tube? Yes (5) No

Is your child on a special diet for a medical condition such as diabetes or PKU? Yes (4) No

If Yes, what kind? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your child allergic to, or intolerant of, any foods? Yes (2) No

If Yes, what foods and describe symptoms and treatment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child regularly have diarrhea? Yes (3) No

Does your child regularly have constipation? Yes (2) No

Does your child regularly vomit? Yes (3) No

In the past six months was your child found to be anemic (low blood iron)? Yes (2) No

Does your child currently have dental problems? Yes (1) No

Does your child take medications daily? Yes (2) No

If yes, what medication and for how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child take vitamins/minerals/home remedies? Yes No

If yes, name of supplement(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your child's activity level ?

\_\_\_\_\_ walks independently \_\_\_\_\_ needs help walking (braces/walker) (2)

\_\_\_\_\_does not walk \_\_\_\_\_ not old enough to walk

Do you have trouble buying enough food to feed your family? Yes (3) No

Does your child participate in WIC ? Yes No

Are you concerned about the amount or variety of foods your child takes in from the following food groups?

No Yes (If yes, check all that apply)

\_\_ milk and dairy foods \_\_ meats, eggs, fish, poultry

\_\_ vegetables \_\_ fruits

\_\_ breads, cereals, rice, beans, and grains \_\_ fats

\_\_ snack foods (chips, soda etc.) \_\_ sugars/sweets

Where do you usually feed your child?

How many meals and snacks does he/she eat most days? \_\_\_\_\_\_\_ meals \_\_\_\_\_\_\_\_ snacks

How long does it take your child to eat? \_\_\_\_\_\_ minutes

Circle the foods that you feel your child does not eat enough of:

milk and milk products meat, beans, eggs fruit and vegetables breads and cereals

How much does your child usually drink in one day (24 hours):

water \_\_\_\_\_ sweet drinks (pop, Kool-Aid, sports drinks, sweet tea) \_\_\_\_\_

juice \_\_\_\_\_ cow’s milk \_\_\_\_\_ other milk \_\_\_\_\_ baby formula \_\_\_\_\_

Uses bottle \_\_\_\_\_ cup \_\_\_\_\_ both \_\_\_\_\_ other \_\_\_\_\_

Do you have additional concerns about your child's growth, nutrition or eating? Yes (1) No

Would you like to speak with the nutritionist about your concerns? Yes No

**Staff to complete:**

Date: \_\_\_\_\_\_\_\_\_\_ Height \_\_\_\_\_\_\_\_\_\_ Weight \_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_

Weight/age % Height/age % Weight/height %

Hgb \_\_\_\_\_ low <11 (2) very low < 10.3 (3) Comments/Actions:

|  |  |  |
| --- | --- | --- |
| Score | Screening Score | Nutrition Risk |
|  | 0 | no risk |
|  | 1 to 4 | low risk |
|  | 5 or more | high risk |