

# Child Questionnaire

Child's Name \_\_\_\_\_ Date \_\_\_\_\_

Name of person completing form \_\_\_\_\_ Relationship to child \_\_\_\_\_

Please answer these questions to help with your WIC visit today.

1. How many people live in your house? Adults: \_\_\_\_\_ Children: \_\_\_\_\_

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2. Does anyone in your household smoke?  Yes  No  
If yes:  Inside  Outside

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3. What does your household use for drinking water?  
 city/town/county water  well water  bottled water  other

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4. Does the refrigerator, stove and microwave in your home work?  Yes  No

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5. In the past month, have there been days when you did not have enough food or money to buy food?  Yes  No  
If yes: Would you be interested in receiving information on local food banks or government assistance agencies?  Yes  No

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6. Does your household receive food stamps?  Yes  No

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7. Is your child in daycare?  
If so which one: \_\_\_\_\_

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8. Has the doctor said your child has any health problems?  Yes  No  
If "yes", list problem(s): \_\_\_\_\_

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9. Most days, do you brush your child's teeth?  Yes  No

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10. Has your child been to the dentist?  Yes  No

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11. Which of these does your child take?  
 multi-vitamins  iron supplement  fluoride supplement  medicine from doctor  
 over-the-counter medicine (like pain relievers, antacids, laxatives)  herbal supplement  
 other \_\_\_\_\_  none

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12. Are your child's shots up-to-date?  Yes  No

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13. Does your child follow a special diet or drink a special formula?  Yes  No  
If "yes", what kind of diet or formula? \_\_\_\_\_

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14. On most days, how many times does your child eat?  
number of meals \_\_\_\_\_ number of snacks \_\_\_\_\_

turn page over →

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15. How many times a week does your child eat meals and snacks away from home or eat take-out meals (not including meals at child care)? It includes vending machines, fast foods, delis and all types of restaurants.

- never or rarely  1-3 times a week  4-6 times a week  more than 6 times a week  not sure

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16. Does your child eat fruit every day?  Yes  No

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17. Does your child eat vegetables every day?  Yes  No

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18. What kind of milk does your child drink?

- skim or fat-free  1% low-fat  2% low-fat  whole  not sure  none  
 other \_\_\_\_\_

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19. Which of these does your child drink everyday?

- milk  water  flavored water  fruit juice  fruit drinks or punch  
 regular soda  sweet tea  sports drinks  other \_\_\_\_\_

How many cups of milk does your child drink daily? \_\_\_\_\_

How many cups of juice does your child drink daily? \_\_\_\_\_

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20. Check any of the following your child uses for drinking?

- regular cup  cup with lid and spout (sippy cup)  baby bottle

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21. Does your child feed him or herself?  Yes  No

If "yes", how?  with fork or spoon  with fingers

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22. Check any of the following foods your child eats:

- raw or unpasteurized milk  
 soft cheeses like feta, brie, blue Cheese or queso fresco or blanco  
 raw or undercooked meat or poultry, fish (including sushi), shellfish, eggs  
 none

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23. Check any of the following items your child eats:

- ashes  baking soda  carpet fibers  chalk  cigarette butts  
 clay  dirt  ice  matches  paint chips  
 starch (corn or laundry)  other \_\_\_\_\_  none

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24. How often does your child have some active play time (like running, jumping, or playing outside)?

- most days  some days  not very often

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25. How many hours a day does your child watch TV?

- 3 or more hours  2-3 hours  1-2 hours  less than 1 hour  doesn't watch TV every day

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26. When you see the nutritionist today, what would you like to talk about?

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Thank you!