

BABY/CHILD NUTRITION QUESTIONS (6–23 months)

Baby's/Child's Name: <u>Samantha Moran</u>	Baby's/Child's Age: <u>6 months</u>
--	-------------------------------------

Please circle or write your answers to the following questions:

1. What month is your baby's/child's next doctor's appointment? Next week

2. How do you know when your baby/child is ready to eat? sucks her fingers
How do you know when your baby/child is full? turns her head away

3. If you breastfeed your baby/child:
How many times in 24 hours do you breastfeed? 5x day plus 1x night
How is breastfeeding going? (not good) 1 2 3 4 5 (great)

4. If you feed your baby/child formula:
How often does your baby/child take a bottle of formula? n/a
How many ounces of formula does your baby/child drink at a feeding? n/a
What brand of formula do you give your baby/child? n/a
Explain how you make the formula. n/a
How is formula feeding going? (not good) 1 2 3 4 5 (great)

5. If your baby or child uses a bottle or a cup:

- ◆ Where are all the places your baby/child takes a bottle or a cup? Bed Stroller Car Seat
Held in someone's arms High-Chair Holds his/her own bottle Other (list) _____
- ◆ What does your baby/child drink from a bottle or a cup?

Water	Rice Water	Hi-C/Punch	Coffee	Breastmilk
Water with Sugar	<u>Cereal</u>	Soda	Tea	Formula
Water with Honey	Skim Milk	Lemonade	Manzanilla/Chamomile Tea	
Water with Karo Syrup	Lowfat Milk	Juice	Pedialyte	
Jell-O Water	Whole Milk	Gatorade	Other _____	

6. What do you feed your baby/child? Family/Table Food Baby Food in Jars Both None

7. Which textures of food do you feed your baby/child?
Pureed Chunky Chopped Soft Pieces Other _____

8. What foods does your baby/child eat?

Cold/Hot Cereal	Beef/Chicken/Fish	Fruits	Yogurt	Crackers
Rice	Eggs Yolks Whites	<u>Vegetables</u>	Ice Cream	Candy
Noodles/Spaghetti	Peanut Butter	Beans	Pudding/Custard	Nuts
Tortillas	Meat Sticks	Soup	Popsicles	Popcorn
Bread/Toast	Hotdogs	Cheese	Raisins	Cookies
French Fries	Chips	Tofu	Other (list) _____	Honey

9. My baby/child uses the following: Breast Bottle Cup Spoon Fork Fingers

10. I give my baby/child: Vitamins Fluoride Iron Drops Medicine None Other _____

11. My baby/child currently has: Allergies Wheezing Rash Constipation Diarrhea None

12. Has your child had a blood lead test? Yes No If yes, when? _____

13. What questions do you have about your baby's/child's eating and growth?
Is she gaining enough weight?

For Staff Use Only

Date: _____ WIC Staff Name: _____

Participant WIC ID #: _____ Length/Height: _____ Weight: _____