**CHILD Nutrition Interview**

**Health Care Provider:**  No Health Care Provider

Do you give WIC permission to share <child’s name>’s WIC information with this health care provider? Yes  No

Health/Medical

**1a. What concerns do you have about <child’s name>’s health?**

**1b. Does <child’s name> have any medical problems diagnosed by a doctor?**  Conditions  No Conditions

Medical Conditions (listed below)

**1c. Is <child’s name> currently on any medication?**  Yes  No

*Listen, ask, and assess for*

* *Medications that compromise nutritional status*

357 – Drug Nutrient Interactions

**1d. Biological Mother** Current Weight \_\_\_\_\_ lbs Current Height \_\_\_\_\_ in Current BMI:

**1e. Biological Father** Current Weight \_\_\_\_\_ lbs Current Height \_\_\_\_\_ in Current BMI:

*Starters/Prompts*

* How do you feel about the way your child is growing and developing?
* Do you mind sharing with me how your child’s last checkup went?
* Do you have anything you would like to talk about today?

Immunizations

**2a. Can we look over <child’s name>’s shot record today?**  Yes  No

**2b. Have any DTaP shots been given?**  Yes  No

**2c. \_\_\_\_# of DTaP immunizations**

Starters/Prompts

* Do you have any concerns about your child getting shots?

- 1st DTap is at 2 months of age

- 2nd DTap is at 4 months of age

- 3rd DTap is at 6 months of age

- 4th DTap is between 15 and 18 months of age

* Do you have any concerns about your child getting routine immunizations?

Oral Health

**3a. How do you take care of <child’s name>’s teeth?**

**3b. Has <child’s name> seen a dentist?**  Yes  No

381 Oral Health Conditions

Starters/Prompts

* What is your routine at home for keeping your child's teeth healthy?
* What is your plan for weaning <child’s name> from a bottle/sippy cup?
* What did the dentist say about <child’s name> teeth?

Life Style

**4a. What types of activities does <child’s name> enjoy?**

**4b. \_\_\_# of hours of TV watching/video playing per day**

**4c. In the past seven days, has <child’s name> been in an enclosed space (i.e. car, home, child care) while someone use tobacco products?**  Yes  No

Starters/Prompts

* What does your child do to stay active?
* What do you and your child like to do together for fun?
* How do you feel about the amount of screen time your child is getting each day?

Nutrition Practices

**5a. Tell me about <child’s name>’s eating and what she/he likes to drink.**

*Listen, ask, and assess for*

* *Appetite*
* *Eating Pattern*
* *Frequency*
* *Eating problems*
* *Beverages/containers*
* *Food preparation*
* *Food jags/refusal*

**5b. What is mealtime like?**

*Listen, ask, and assess for*

* *Environment*
* *Tone of mealtime*
* *When, where, with whom?*

**5c. Is there anything you would like to see different about <child’s name>’s eating?**

**5d. Are there any foods that you would like to see <child’s name> eat more/less of?**

**5e. Does <child’s name> take any vitamins, minerals, herbs, or dietary supplements?**  Yes  No

**425 – Nutrition Practices**

425a – Inappropriate Beverages as Primary Milk Source

425c – Improper Use of Bottles, Cups, or Pacifiers

425e – Feeding Foods Potentially Contaminated with Harmful Microorganisms

425g – Dietary Supplements with Potentially Harmful Consequences

425i –Eating of Non-Food Items (Pica)

425b – Feeding Sugar Sweetened Beverages

425d – Feeding Practices that Disregard Developmental Stage of Child

425f – Diet Very Low in Calories and/or Essential Nutrients

425h – No Dietary Supplement of Vitamin D or Fluoride (when necessary)

**Other Nutrition Risks**

428 – Risk Associated with Complimentary Feeding age 4-23mo

353 – Food Allergies (must list type)

401 – Failure to Meet Dietary Guidelines for Americans

Starters/Prompts

* How do you feel about <child's name> eating?
* How does your child do with variety or trying new foods?
* What do you do if your child doesn’t want to eat or only wants to eat a certain kind of food?

Social Environment

**6a. What else can I help you with?**

*Listen, ask, and assess for:*

* *Abuse/neglect in the last 6 months*
* *Limited ability to make appropriate feeding decisions or prepare foods*

901 – Recipient of Abuse/Neglect  902 – Limited Ability to Make Feeding Decisions/Prepare Food

Starters/Prompts

* What safety concerns do you have about where you live?
* What level of trust do you have for the people who care for or spend time with your child?
* Is there anything else we have not discussed today that you hoped we would?