Ohio Department of Health | OHIO WIC Women, Infants, and Children Program | Grow Together Breastfeed

Complete frontside ONLY

Child Health Assessment

Date(s): _____ **Child's Name:** _____

Parent/Guardian Name: _____ **Relationship:** _____

Child Health History Questions *(please complete all questions on this side – leave the backside blank)*

Where does your child go for healthcare? Doctor/clinic name: _____

Does your child attend well visits? ☐ Yes ☐ No

Is your child up to date on shots? ☐ Yes ☐ No ☐ I don't know

Does your child receive any therapy or other services? ☐ Physical ☐ Occupational ☐ Speech

☐ Home visiting: _____ ☐ Other: _____ ☐ N/A

Does your child have any medical conditions, or recent surgery, illness, food allergies, or injury? Please describe:

_____

Please list any medication(s) your child takes: _____ ☐ N/A

Is your child tube fed? ☐ Yes, Please describe:_____ ☐ No

Does your child have: ☐ Constipation ☐ Diarrhea ☐ Vomiting ☐ N/A

Has anyone in your family been tested for lead? ☐ Yes (levels): _____ ☐ No ☐ I don't know

Do you or your dentist have any dental concerns? ☐ Yes _____ ☐ No ☐ I don't have a dentist

Do you live in a temporary place (shelter, hotel, etc.)? ☐ Yes ☐ No

Has your child entered foster care or moved foster care homes, within the past six months? ☐ Yes ☐ No

Has your child been physically, verbally, sexually abused, or neglected? ☐ Yes ☐ No

Do you worry about running out of food? ☐ Yes ☐ No

Do you use local food banks/pantries? ☐ Yes ☐ No

What questions or concerns do you have about your child's health, eating habits, and breastfeeding?

This portion is to be completed by WIC staff

☐ **New Cert (*date*):** _____ ☐ **Recert (*date*):** _____ ☐ **HA (*date*):** _____ ☐ **Continue Goal**

Location of WIC Program Application: _____

HT _____ **WT** _____ **Hgb** _____ (optional)

Nutrition, Breastfeeding, and Physical Activity Questions *(to be completed by WIC staff member)*

Share with me the physical activities your child enjoys:_____

Tell me about screen time and your child: Time/day _____ Days/week _____

Tell me about your experience with giving your child breast milk:

_____

Describe what your child eats and drinks each day:

_____

Targeted diet assessment may include:

- Vitamins, iron sources, enhancers, inhibitors
- Dairy/calcium/vitamin D
- Whole grains/fiber
- Protein sources
- Fruits and vegetables
- Sugar sweetened drinks/foods
- Foods limited/refused/avoided
- Meals away from home/fast food
- Feeding tube
- Self-feeding (progression and eating skills)
- Family meals/mealtimes
- Religious or cultural diets
- Same foods as rest of the family
- Bottle use/propped/sleep with bottle
- What's in the bottle?
- Open/sippy cup use
- Water source
- Choking

Does your child eat unsafe foods or non-food items? ☐ Yes ☐ No ☐ Concerns: _____

Check for unsafe foods:

- Raw/undercooked meats
- Uncooked deli and processed meats
- Unpasteurized foods

Check for non-food items:

- Paint chips, starch, coffee grounds
- Ice
- Paper
- Dirt/Clay

Caregiver with limited feeding decision/inability to prepare foods:

☐ Current/history of alcohol or substance abuse ☐ Mental illness, including severe depression

☐ Intellectual disability ☐ Physical disability ☐ Age ≤ 17 years ☐ N/A

Notes: