

WIC HEALTH QUESTIONNAIRE - Child

Date: _____

Child's Name	Birth Date	Expected Due Date (If <2 years old)	Age
Female / Male (Circle one)			(in months if less than 2 years; in years and months if over 2)

	Circle Yes or No		NRFs
1. Is your child under two years of age? (If no, skip to question 2; if yes, answer the following): a) Child's birth weight _____ Birth length _____ b) Was your child ever breastfed? If yes, for how long? _____ Why was breastfeeding stopped? _____	No	Yes	
2. Is your child up to date on his/her immunizations? Please bring shot records.	Yes	No	Refer
3. Has your child had a blood lead test done in the last 12 months? Lead level or test result (if known) _____	No	Yes	System Assigned NRF
4. Does your child take any herbs or dietary supplements? If yes, describe: _____	No	Yes	CG CH
5. Does your child have a medical problem diagnosed by a doctor (such as birth defects/handicaps, hepatitis, HIV/AIDS, diabetes, food allergy or asthma requiring daily medication)? If yes, describe: _____	No	Yes	Medical Condition
6. Does your child have any dental problems (such as severe tooth decay and/or swallowing/chewing difficulties)? If yes, describe: _____	No	Yes	
7. Has your child had major surgery in the last two months?	No	Yes	
8. Does your child have any of the following? Frequent constipation <input type="checkbox"/> Frequent vomiting <input type="checkbox"/> Frequent diarrhea <input type="checkbox"/> Frequent illness <input type="checkbox"/> If yes, describe how long/how often: _____	No	Yes	Counsel/ Refer
9. Is this child in foster care? If yes, when did s/he move to this foster care home? _____	No	Yes	94
10. Do you have any questions or concerns about: Picky eaters <input type="checkbox"/> What foods are best <input type="checkbox"/> Well Child clinic <input type="checkbox"/> Snacks <input type="checkbox"/> Eating vegetables <input type="checkbox"/> Immunizations <input type="checkbox"/> Lead exposure <input type="checkbox"/> Child support payments <input type="checkbox"/> Other questions: _____ Would you like information about: Medicaid <input type="checkbox"/> TANF <input type="checkbox"/> Food Stamps <input type="checkbox"/>	No	Yes	Counsel/ Refer
	No	Yes	
11. Does anyone living in your household smoke inside the home?	No	Yes	ES
12. When does your child see a doctor or go to a clinic? For regular check-ups <input type="checkbox"/> Just when sick <input type="checkbox"/> Both <input type="checkbox"/> Neither <input type="checkbox"/> Name of doctor or clinic: _____			Counsel/ Refer
13. Do you clean/brush your child's teeth daily?	Yes	No	
14. Does your child receive regular dental care?	Yes	No	

Questionnaire assessed by: _____ (Staff)

Notes: _____
 Colorado Department of Public Health and Environment/Nutrition Services
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