Child Nutritional Assessment

Date Completed: ____/____/_____ Name: _____

Completed By: ☐ Head Start Staff Specify: _____

☐ Medical Provider Specify: _____

A. Infants:

Eating frequency (times per day): |___|___| Amount consumed in 24 hours: |___|___|___| ounces

Type of food consumed: ☐ Breast Milk ☐ Formula ☐ Milk ☐ Other: Specify _____

Feeding Method: ☐ Breast Fed ☐ Bottle Fed ☐ Other: Specify _____

B. Toddlers:

Eating Frequency (times per day): |___|___|

At what age did the child start doing each of the following:

Eat solid food: |___|___| months Drink from a cup: |___|___| months Feed self: |___|___| months

Dietary Habits:

Favorite Foods: _____

Least Favorite Foods: _____

	Yes
Child takes vitamin/ mineral supplements?	☐
Supplements contain iron?	☐
Supplements contain fluoride?	☐
Supplements were prescribed?	☐
Foods not eaten for medical, religious or personal reasons?	☐
Child on a special diet?	☐
Change in child's appetite in the past month?	☐
Child takes a bottle?	☐
Child eats or chews things that aren't food?	☐
Child has trouble chewing or swallowing?	☐
Child often has:	
Diarrhea	☐
Constipation	☐
Concerns about what the child eats?	☐

Comments:

Usual Food Group Eating Frequency:

	Approximate Number of Times Each Week								
	0	1	2	3	4	5	6	7	7+
A. Milk, cheese, yogurt	☐	☐	☐	☐	☐	☐	☐	☐	☐
B. Meat, poultry, fish, eggs; or dried beans/peas, peanut butter	☐	☐	☐	☐	☐	☐	☐	☐	☐
C. Rice, grits, bread, cereal, tortillas	☐	☐	☐	☐	☐	☐	☐	☐	☐
D. Greens, carrots, broccoli, winter squash, pumpkin, sweet potatoes	☐	☐	☐	☐	☐	☐	☐	☐	☐
E. Oranges, grapefruit, tomatoes (fruit/juice)	☐	☐	☐	☐	☐	☐	☐	☐	☐
F. Other fruits and vegetables	☐	☐	☐	☐	☐	☐	☐	☐	☐
G. Oil, butter, margarine, lard	☐	☐	☐	☐	☐	☐	☐	☐	☐
H. Cakes, cookies, sodas, fruit drinks, candies	☐	☐	☐	☐	☐	☐	☐	☐	☐