DIETARY QUESTIONNAIRE FOR CHILDREN
Pennsylvania Department of Health -- WIC Program

Name: ________________________________ F.I.D. #: _____________________________
D.O.B.: ________________________________ Endorser Name _____________________________
Date: _________________________________

Please fill in the blanks and check all answers that apply.

1. Does your child have any medical problems? ☐ No ☐ Yes Dental problems or cavities? ☐ No ☐ Yes
   Please list or describe:

   Does your child take any medicine?
   Please list:

2. Is your child on a special diet such as Vegetarian or Macrobiotic? ☐ No ☐ Yes
   If yes, please describe:

   Do you limit any of the following in your child’s diet? ☐ No ☐ Yes
   ☐ Sugar ☐ Calories ☐ Salt ☐ Fat ☐ Carbohydrate ☐ Other ___________________________
   Reason: ___________________________

3. Does your child take any of the following?
   ☐ Multivitamins ☐ Fluoride ☐ Vitamin D ☐ Iron ☐ Herbal teas/supplements ☐ Other ________

4. Describe how you defrost foods: ☐ Under running water ☐ In the refrigerator ☐ On the counter ☐ In the microwave
   Does everyone wash their hands before and after food preparation? ☐ No ☐ Yes
   Do you use different cutting boards for fruits/vegetables and raw meats? ☐ No ☐ Yes

5. Check which items you have at home that work:
   ☐ Running water ☐ Stove ☐ Refrigerator ☐ Freezer ☐ Microwave
   If you have a thermometer in the refrigerator, what is the temperature? ______
   Freezer temperature? ______

6. How much milk does your child drink each day?
   ☐ Less than 1 cup ☐ 1 to 2 cups ☐ 3 or more cups ☐ Does not drink milk
   Check which kinds of milk your child drinks:
   Cow’s milk: ☐ Whole ☐ 2% ☐ 1% ☐ Skim ☐ Lactose free ☐ Chocolate/Strawberry
   ☐ Goat’s milk ☐ Soy milk ☐ Almond milk ☐ Other ________

7. Check what other beverages your child drinks:
   ☐ Soda/Pop ☐ Kool-Aid ☐ 100% Juice ☐ Drinks in boxes, pouches, etc.
   ☐ Juice drinks (punch, cocktail, etc.) ☐ Tea ☐ Gatorade ☐ Energy drinks ☐ Other ________
   Do you add water to these beverages? ☐ No ☐ Yes

8. Does your child drink plain water? ☐ No ☐ Yes How much each day? ☐ Less than 1 cup ☐ 1-2 cups ☐ 3 or more cups

9. Does your child use a bottle? ☐ No ☐ Yes What goes in the bottle? ___________________________
   Does your child go to sleep with the bottle or walk around with it during the day? ☐ No ☐ Yes

10. Does your child use a sippy cup? ☐ No ☐ Yes
    Describe when? ☐ Meals ☐ Snacks ☐ Walks around with it ☐ Goes to sleep with it

11. Does your child eat baby foods? ☐ No ☐ Yes Describe the texture: ☐ Blended smooth ☐ With chunks
    Does your child eat table foods? ☐ No ☐ Yes Describe the texture: ☐ Mashed ☐ Finely chopped ☐ Chunky ☐ Regular

12. Is your child able to self-feed? ☐ No ☐ Yes Describe how: ☐ Spoon ☐ Fork ☐ Fingers ☐ Other ________

13. Is your child having any problems with: ☐ Poor appetite ☐ Food textures ☐ Chewing food ☐ Swallowing food
    ☐ Nausea or vomiting ☐ Diarrhea ☐ Constipation ☐ None of these

14. Is your child allergic to any foods? ☐ No ☐ Yes

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15. How many meals does your child eat each day? □ 1 □ 2 □ 3 or more
   Besides meal time, when is your child given something to eat? □ At snacks □ When fussy or crying
   Do you offer food as a reward? □ No □ Yes □ If yes, what foods?
   Do you require your child to eat certain foods or finish plate? □ No □ Yes

16. Check any concerns you have with getting your child to eat well:
   □ Picky eater □ Leaves food on the plate □ Wants the same foods all the time □ Begs for snacks between meals
   □ Wants milk or juice all day long □ None of these □ Other __________________________

17. Besides your home, where does your child usually eat? □ Day care/baby sitter □ Head start □ Relatives □ Usually at home

18. Check how often your child eats the foods listed below:
   Meats, chicken, fish: □ Daily □ Some days □ Never
   Grains (pasta, rice, bread, cereal, tortilla): □ Daily □ Some days □ Never
   Fruits: □ Daily □ Some days □ Never
   Eggs: □ Daily □ Some days □ Never
   Vegetables: □ Daily □ Some days □ Never
   Peanut butter: □ Daily □ Some days □ Never
   Cheese: □ Daily □ Some days □ Never
   Beans (pinto, kidney, etc): □ Daily □ Some days □ Never

19. How many times a day does your child eat snacks? □ 1 □ 2 □ 3 or more
   Check the foods your child eats for snacks:
   □ Cookies □ Crackers □ Chips □ Pretzels □ Cereal □ Cereal bars □ Candy
   □ Cheese □ Yogurt □ Fruit □ Pudding □ Vegetables □ Other __________________________

20. How often does your child eat at fast food places such as Burger King or McDonalds?
   □ Everyday □ A few times a week □ Once a week □ Once a month □ Never

21. How many hours a day does your child spend watching TV, playing video games or using the computer or phone?
   □ 1 or less □ 2 □ 3 or more

22. Does your child eat any of these foods? If yes, please check.
   □ Popcorn □ Whole grapes □ Hard candy □ Lollipops □ Raw vegetables □ Nuts or seeds
   □ Peanut butter □ Gummies □ Jelly beans □ Hot dogs □ Pretzels □ Chips
   □ Raisins/dried fruit □ Other __________________________

   Does your child eat any of these foods? If yes, please check.
   □ Raw cookie dough or cake batter □ Soft cheese like feta or brie □ Bean sprouts
   □ Hot dogs, deli or lunch meats □ Bean sprouts
   □ Raw or undercooked eggs, meat, or fish □ Milk, juice or cider from mill or farm (if unpasteurized)

23. Does anyone smoke inside your home? □ No □ Yes

24. Does your child eat any of the following?
   □ Laundry starch □ Soil □ Chalk □ Paint chips □ Cigarette ashes □ Ice (in large quantities)
   □ Burnt matches □ Clay □ Carpet fibers □ Cornstarch □ Foam rubber □ Other ______________

25. Has your child been tested for lead? □ No □ Yes □ Not sure

26. Do you ever have to choose between buying food and paying bills?
   □ A lot □ Sometimes □ Rarely □ Never

27. What questions do you have today about your child’s nutrition or diet? __________________________

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