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

Name: _____ D.O.B.: _____

F.I.D. #: _____ 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

Which foods? ☐ Seafood ☐ Peanuts ☐ Nuts ☐ Eggs ☐ Wheat ☐ Soy ☐ Milk ☐ Other_____

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 ☐ Hot dogs, deli or lunch meats ☐ Raw or undercooked eggs, meat, or fish
☐ Soft cheese like feta or brie ☐ Bean sprouts ☐ 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?** _____