

TMC CHILD NUTRITION ASSESSMENT FORM

THIS FORM IS TO BE USED BY THE NUTRITION CONSULTANT OR COORDINATOR FOR NUTRITION RELATED REFERRALS.

Center Name: _____

Child's name: _____ DOB: _____

See family file, physical exam or WIC report for Hgb/Hct and/or growth charts for weight, height (WT for HT), head-circumference and body mass index (BMI) data.

	<u>Yes</u>	<u>No</u>
Child takes vitamin/ mineral supplements?	<input type="checkbox"/>	<input type="checkbox"/>
Supplements contain iron?	<input type="checkbox"/>	<input type="checkbox"/>
Supplements contain fluoride?	<input type="checkbox"/>	<input type="checkbox"/>
Supplements were prescribed?	<input type="checkbox"/>	<input type="checkbox"/>
Change in child's appetite in the past month?	<input type="checkbox"/>	<input type="checkbox"/>
Child takes a bottle?	<input type="checkbox"/>	<input type="checkbox"/>
Child eats or chews things that aren't food?	<input type="checkbox"/>	<input type="checkbox"/>
Child often has:		
Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Concerns about what child eats?	<input type="checkbox"/>	<input type="checkbox"/>

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

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

Weight: _____ Height: _____ Head Circumference: _____ BMI: _____ Hgb/Hct: _____

Dietary Habits:

Favorite foods: _____

Least favorite foods: _____

Usual Food Group Eating Frequency

Approximate Number of Times Each Week

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

Below describe the nutrition care process for this child and follow up date:

Print Name & Title: _____

Signature _____ Date _____

