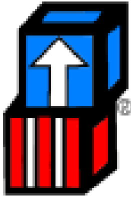

Androscoggin Head Start
and Child Care

Early Head Start Nutritional Intake Questionnaire

Used for 6 weeks through 9 Months

Child's Name: ____ DOB: _____________________

Is your child on WIC: YES or NO *Does your family use food stamps: YES or NO*

6 week thru 3- month Assessment Date: __________ Parent initials: _______

____ My child is breastfed and nurses ____ times per day and usually nurses for ____ minutes each time I feed him/her.

____ My child is bottled fed and I feed him/her ______ times per day and give about ______ ounces per feeding.

Type/Brand of formula _______________Iron fortified___ Bottle type ________ Nipple type _________

____ Does your child drink juice?_______ If so how much? ____________________

____ Does your child have allergies to any formulas? ____

____ Does your child take vitamins? ______________________ Fluoride? ______________________

____ Does your child eat other foods? Type of food (i.e. cereal)? ________________________________

____ Does your child get put to bed with a bottle? ____ Yes ____No

____ Do you sweeten or add salt to your child's water or food? ____ Yes ____No

Do you have any questions or concerns about your child's appetite? ____
____

3-6 Month Assessment Date: __________ Parent initials: _______

____ My child is breastfed and nurses ____times per day and usually nurses for ____minutes each time I feed him/her.

____ My child is bottled fed and I feed him/her ______times per day and give about______ ounces per feeding.

Type/Brand of formula _______________Iron fortified___ Bottle type ________ Nipple type ________

____ Does your child drink juice?_______ If so how much? _____________________

____ Does your child have allergies to any formulas? ____

____ Does your child take vitamins? ______________________ Fluoride? ______________________

____ My child is eating solid foods ____Yes ____No _____ times per day. _____ table food ______ commercially jarred food.

Types of food she/he is eating: ____

____ Does your child get put to bed with a bottle? ____ Yes ____No

____ Do you sweeten or add salt to your child's water or food? _________________________________

Do you have any questions or concerns about your child's appetite? ____
____

6-9 Month Assessment Date: _________ Parent initials_______

____ My child is breastfed and nurses ____times per day and usually nurses for ____minutes each time I feed him/her.

____ My child is bottled fed and I feed him/her ______times per day and give about______ ounces per feeding.

Type/Brand of formula _______________Iron fortified___ Bottle type ________ Nipple type ________

____ Does your child drink juice?_______ If so how much? ______________________

____ Does your child have allergies to any formulas? ____

____ Does your child take vitamins? ________________________ Fluoride? _______________________

____ My child is eating solid foods ____Yes ____No _____ times per day. _____ table food ______ commercially jarred food.

Types of food she/he is eating: ____

____ Does your child get put to bed with a bottle? ____ Yes ____No

____ Do you sweeten or add salt to your child's water or food? ___________________________________

Do you have any questions or concerns about your child's appetite? ____

Parent Signature: ____ Date: ________________

Staff Signature: ____ Date: _______________

For ages 1-5 use the COPA nutritional questionnaire

Is a Food and Allergy Report required?

Copy sent to ____

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