Parent Nutrition/Feeding Questionnaire (for Ages 0-5 years) - PEACH

Please print

Child's Name: _____ Parent/Guardian Name: _____

Date of Birth: _____ Telephone Number: _____

Sex: _____ Best time to call: _____

Dr. Name: _____ Parent email: _____

Height: _____ Weight: _____ Date: _____ Parent address: _____

Is your child currently followed in a WIC Clinic? _____

Has your child now or ever been seen by a Dietitian or Nutritionist? _____

If so, by whom? _____

DIRECTIONS: Please circle/check your answers. Total the score by adding the number in the right-most columns of the questions answered "YES".

1	Does your child have a health problem (do **not** include colds or flu)? If yes, what is it?	YES		NO		1
2	Is your child: (If you check any of the below, please circle YES) Small for age? ☐ Too Thin? ☐ Too Heavy? ☐	YES		NO		3
3	Does your child have feeding problems? If yes, what are they?	YES		NO		3
4	Is your child's appetite a problem? If yes, describe:	YES		NO		1
5	Is your child on a special diet? If yes, what type of diet?	YES		NO		2
6	Does your child take medicine for a health problem? (Do **not** include vitamins, iron or fluoride) Name of medicine(s):	YES		NO		1
7	Does your child have food allergies? If yes, to what foods?	YES		NO		1
8	Does your child use a feeding tube or other special feeding method? If yes, explain:	YES		NO		4
9	Does your child have trouble eating any of these foods (Check all that apply) Milk ☐ Meats ☐ Vegetable ☐ Fruits ☐	YES		NO		1
10	Does your child have any of these problems? (Check all that apply) Sucking ☐ Swallowing ☐ Chewing ☐ Gagging ☐ Meals lasting longer then 30 minutes ☐	YES		NO		3
11	Does your child have any of these problems ? (Check all that apply) Loose stools ☐ Hard stools ☐ Throwing up ☐ Spitting up ☐	YES		NO		3
12	Does your child eat clay, paint chips, dirt or any other things that are not food? If yes, what? ☐	YES		NO		2
13	Does your child refuse to eat, throw food, or do other things that upset you at mealtime? If yes, explain:	YES		NO		2
14	For infants **under 12 months** who are bottle fed: Does your child drink less than 3 (8-ounce) bottles of formula or milk per day?	YES		NO		1
15	For children **over 12 months**: (Check if applies and circle the YES) Is your child **not** using a cup? ☐ Is your child **not** finger feeding? ☐	YES		NO		1
16	For children **over 18 months**: Does your child still take most liquids from a bottle?	YES		NO		2
17	For children **over 18 months**: Circle YES if your child is **not** using a spoon	YES		NO		2

Other comments: **TOTAL:** _____

Please send PEACH tools for which nutrition evaluation is requested with a signed Authorization for Exchange of Information to Stephany Brimeyer:

Stephany Brimeyer, MPH, RD, LD
Early ACCESS/ Child Health Specialty Clinics Nutrition Coordinator
865 Lincoln Rd, Suite 400
Bettendorf, Iowa 52722

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Scored by:_____ Date: _____ Agency and phone:_____