



Department of Health



Complete frontside ONLY

# Infant Health Assessment

Date(s): \_\_\_\_\_ Infant's Name: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

## Infant Health History Questions *(please complete all questions on this side – leave the backside blank)*

Were you/baby's mother on WIC during pregnancy?  Yes  No  I don't know

Where does your baby go for healthcare? Doctor/clinic name: \_\_\_\_\_

Does your baby attend well visits?  Yes  No

Is your baby up to date on shots?  Yes  No  I don't know

Does your baby receive any therapy or other services?  Physical  Occupational  Speech

Home visiting: \_\_\_\_\_  Other: \_\_\_\_\_  N/A

Does your baby have any medical conditions, or recent surgery, illness, food allergies, or injury? Please describe:

\_\_\_\_\_

Please list any medication(s) your baby takes: \_\_\_\_\_  N/A

Is your baby tube fed?  Yes Please describe: \_\_\_\_\_  No

Does your baby have:  Constipation  Diarrhea  Vomiting  Gassiness  N/A

Has anyone in your family been tested for lead?  Yes (levels): \_\_\_\_\_  No  I don't know

How do you clean your baby's teeth/gums? \_\_\_\_\_

Do you live in a temporary place (shelter, hotel, etc.)?  Yes  No

Has your child entered foster care or moved foster care homes, within the past 6 months?  Yes  No

Has your baby been physically, verbally, sexually abused or neglected?  Yes  No

Where does your baby sleep?  Crib  Bassinet  Cribette/Pack n Play  With another person/child  Other

How many wet and dirty diapers does your baby have each day? Wet: \_\_\_\_\_ Dirty: \_\_\_\_\_

Do you worry about running out of food?  Yes  No

Do you use local food banks/pantries?  Yes  No

What questions or concerns do you have about your baby's health, eating habits, and breastfeeding?

This portion is to be completed by WIC staff

New Cert (date): \_\_\_\_\_  Recert (date): \_\_\_\_\_  HA (date): \_\_\_\_\_  Continue Goal

Location of WIC Program Application: \_\_\_\_\_

HT \_\_\_\_\_ WT \_\_\_\_\_ Hgb \_\_\_\_\_ (optional)

**Nutrition, Breastfeeding, and Physical Activity Questions** (to be completed by WIC staff member)

Check for safe sleep (bedding/wraps/pacifier) \_\_\_\_\_

How do you interact with your baby? \_\_\_\_\_

Tell me about screen time and your baby: Time/day \_\_\_\_\_ Days/week \_\_\_\_\_

Tell me about your experience with giving your baby breast milk: \_\_\_\_\_

Describe what your baby eats and drinks each day:

**Targeted diet assessment may include:**

- Breastfeeding challenges
- Feedings per day/ounces
- Number of bottles/days
- Paced feeding
- Hunger and feeding cues
- Formula mixing and preparation
- Water source
- Choking/gagging
- Religious or cultural diets
- Bottle use/propped/sleeping
- What's in the bottle?
- Cup/sippy cup use
- What age did your baby start eating foods?
- Food safety, handwashing, leftover milk
- Feeding tube

**Caregiver with limited feeding decision/inability to prepare foods:**

Current/history of alcohol or substance abuse  Mental illness, including severe depression  
 Intellectual disability  Physical disability  Age ≤ 17 years  N/A

Notes: