CHILD HEALTH RECORD:

FORM 6, NUTRITION

PART I. TO BE COMPLETED BY HEAD START STAFF DURING PARENT/GUARDIAN INTERVIEW

CHILD'S NAME:_____ SEX:_____ BIRTHDATE:_____

DIETARY HABITS

1. WHAT FOODS DOES YOUR CHILD ESPECIALLY LIKE?_____

2. ARE THERE ANY FOODS YOUR CHILD DISLIKES?

	Yes	No
3. DOES YOUR CHILD TAKE VITAMINS AND MINERAL SUPPLEMENTS?		
(a) If "yes", what kind are they? _____		
(b) Do they contain iron?		
(c) Do they contain fluoride?		
(d) Were they prescribed?		
4. IS THERE ANY FOOD YOUR CHILD SHOULD NOT EAT FOR MEDICAL, RELIGIOUS, OR PERSONAL REASONS?	*	
5. IS YOUR CHILD ON A SPECIAL DIET?	*	
(a) What kind? _____		
6. HAS THERE BEEN A BIG CHANGE IN YOUR CHILD'S APPETITE IN THE LAST MONTH?	*	
7. DOES YOUR CHILD TAKE A BOTTLE?	*	
8. DOES YOUR CHILD EAT OR CHEW THINGS THAT AREN'T FOOD?	*	
9. DOES YOUR CHILD HAVE TROUBLE CHEWING OR SWALLOWING?	*	
10. DOES YOUR CHILD OFTEN HAVE:	*	
(a) Diarrhea?		
(b) Constipation?	*	
11. DO YOU HAVE ANY CONCERNS ABOUT WHAT YOUR CHILD EATS?	*	

12. ABOUT HOW OFTEN DOES YOUR CHILD EAT A FOOD FROM EACH OF THE FOLLOWING GROUPS?

Approximate Number of Times a Week *(circle the number(s) nearest to parent's answer)*

(a) Milk, cheese, yogurt.	0*	1*	2*	3	4	5	6	7	7+
(b) Meat, poultry, fish, eggs; or Dried beans/peas, peanut butter.	0*	1*	2*	3	4	5	6	7	7+
(c) Rice, grits, bread, cereal, tortillas.	0*	1*	2*	3	4	5	6	7	7+
(d) Greens, carrots, broccoli, winter squash, pumpkin, sweet potatoes.	0*	1*	2	3	4	5	6	7	7+
(e) Oranges, grapefruit, tomatoes (fruit/juice).	0*	1*	2*	3	4	5	6	7	7+
(f) Other fruits and vegetables.	0*	1*	2	3	4	5	6	7	7+
(g) Oil, butter, margarine, lard.	0*	1*	2	3	4	5	6	7	7+*
(h) Cakes, cookies, sodas, fruit drinks, candy.	0	1	2	3	4	5	6	7	7+*

***Starred answers may require follow-up. Explain details or give additional comments here.**

PART II. TO BE COMPLETED BY HEAD START STAFF, HEALTH CARE PROVIDER, OR NUTRITIONIST

13. GROWTH

DATE	AGE	HEIGHT *(no shoes, to nearest 1/8 in.)*	WEIGHT *(light clothing, to nearest 1/4 lb..)*
	_____yrs._____mo.		
	_____yrs._____mo.		
	_____yrs._____mo.		

14. ANEMIA SCREEN

	DATE	HEMOGLOBIN*	OR HEMATOCRIT *
SCREENING			
RESCREENING			

***Hgb less than 11 or Hct less than 34 require follow-up**

15. CRITERIA FOR REFERRAL OR FURTHER INVESTIGATION

(Review items 2 through 13. If there are answers in starred (*) areas, or if growth is not within the typical range, check the appropriate box(es) below and consult a nutritionist or physician.)

- ☐ Suspect dietary problem or inadequate food intake *(from Questions 2 to 12)*
- ☐ Hgb. less than 11 gm. or Hct. less than 34% *(from Question 14)*
- ☐ Underweight *(weight less than typical, from Growth Chart 1 or 4)*
- ☐ Overweight *(weight greater than typical, from Growth Chart 1 or 4)*
- ☐ Short for Age *(height less than typical, from Growth Chart 2 or 5)*
- ☐ Wt. for Ht. *(greater or less than typical, from Growth Chart 3 or 6)*

COMMENTS *(use additional page if needed)*

Signature_____ Title_____ Date_____