1. Check all your baby has had in the last month:
   - diaper
   - constipation
   - vomiting
   - nausea
   - reflux
   - spitting up
   - difficulty swallowing
   - dental problems
   - special diet
   - health or medical problem
   - food allergy or problem
   - none

2. Check all that your baby takes:
   - medicine
   - herbal teas / herbal products
   - vitamins / minerals
   - home remedies
   - none

3. Check all that your baby uses to eat or drink:
   - breast
   - baby bottle
   - sippy cup
   - his/ her fingers
   - regular cup
   - spoon or fork
   - other

4. Do you have a working stove, refrigerator, and sink? □ Yes □ No

5. In one day (24 hours) how many does your baby usually have? _____ wet diapers per day _____ dirty diapers per day

6. Check all that you are feeding your baby and answer the following questions:
   - Breastmilk  □ How many times do you breastfeed or give breastmilk in one day (24 hours)? ______________
     □ How long do you plan to breastfeed?
     □ Are you having any problems with or do you have any questions about breastfeeding? □ Yes □ No
     □ If yes, ______________
     □ Do you ever pump your breastmilk? □ Yes □ No
     □ If yes, how many times per day? ______________
   - Infant Formula  □ Name of formula?
     □ What Type? □ concentrate □ powder □ ready-to-feed
     □ How do you make formula?  □ Concentrate: _____ oz of formula to _____ oz of water
     □ Powder: _____ scoops of formula to _____ oz of water
     □ How many bottles does your baby drink in one day (24 hours)? _____  □ How many ounces are in each bottle? _____
     □ What type of water do you use to mix the formula? □ city □ well □ bottled water □ bottled “nursery” water
     □ Do you boil the water that is added to the formula? □ Yes □ No
     □ If boiled, for how long? _____ minutes
     □ How are the baby bottles cleaned?

7. Check “Yes “ or “No” to each question below:
   - Does your baby fall asleep with a bottle? □ Yes □ No
   - Does your baby drink from a bottle that is being propped up? □ Yes □ No
   - Do you put cereal, other foods, or juice in your baby’s bottle? □ Yes □ No
   - Is your baby fed breastmilk or formula that has been in the refrigerator for more than 24 hours? □ Yes □ No
   - Is your baby fed breastmilk or formula that has been in a bottle 1 hour after the start of a feeding? □ Yes □ No
   - Is your baby fed breastmilk or formula that has been in a bottle from an earlier feeding? □ Yes □ No

8. Check all the foods or beverages you give your baby:
   - □ Breast milk  □ Gatorade®  □ Mixed dinners
   - □ Cow’s milk  □ Kool-Aid®  □ Luncheon meats
   - □ Soy milk  □ Soda  □ Meat  □ hot dogs / sausage  □ Corn syrup  □ nuts, seeds
   - □ Goat’s milk  □ Tea  □ Fruits  □ Fish  □ Honey  □ peanut butter
   - □ Water  □ Fruit drinks  □ Vegetables  □ Shellfish  □ Egg yolk (yellow)  □ popcorn
   - □ 100% Fruit Juice  □ Desserts  □ French fries  □ Egg white  □ hard candies
   - □ Other

   How do you know when your baby is hungry?
   How do you know when your baby is full?

9. Do you have any questions or concerns about your baby’s health, diet, feeding, growth or development? □ Yes □ No
   □ If yes, please describe ________________________________

10. Please offer any suggestions on what WIC can do to better serve you and your family. ________________________________

STOP HERE
## Nutrition Education Flow Sheet (Infant)

### Inappropriate Nutrition Practices for Infants

If yes, document how.

- [ ] Yes
- [ ] No

- Breastmilk or Formula Substitute. \(^{(6,8)}\)
- Inappropriate use of bottles or Sugar-Containing Fluids. \(^{(7,8)}\)
- Inappropriate Introduction of Solid Foods. \(^{(8)}\)
- Feeding Practices not Developmentally Appropriate. \(^{(5,8)}\)
- Potentially unsafe food consumption. \(^{(6,7,8)}\)
- Inappropriate Formula Preparation. \(^{(6)}\)
- Restrictive Nursing. \(^{(6)}\)
- Restrictive Diet. \(^{(6,8)}\)
- Lack of proper Sanitation. \(^{(4,6,7)}\)
- Potentially Harmful Dietary Supplements. \(^{(2)}\)
- Lack of Essential Dietary Supplements. \(^{(2)}\)

Note: the number(s) after each statement correspond to the related nutrition questionnaire.

### Primary Nutrition Contact

**Comments:**

**Plan / Goals:**

*Required Documentation*

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### Topics Discussed

- Reinforce Good Points in Diet
- Nutritional Value of WIC Foods
- Assessment of Latch & Positioning
- Frequency/Duration/Encouragement
- Supply & Demand / Supplementing
- Growth Spurs
- Problems / Barriers (Specify)
- Iron Fortified Formula
- Formula Preparation
- Techniques of Bottle Feeding
- Spitting Up / Reflux
- Delay Solids Until 5-6 Months
- Beginning Solids (Type & Amounts)
- Iron Fortified Infant Cereal
- Offer Water Daily When Starting Solids
- Single Food Introduction (Baby Foods)
- Prevention of Choking
- Encouraging Self Feeding Skills
- Empty Calories & Sweet Drinks
- Dental Care / Weaning to Cup / Baby Bottle Caries
- Modeling Positive Behaviors
- Stress Free Feeding
- Picky Eating
- Goal Setting
- Immunizations
- *Alcohol, Tobacco, Drugs & other Harmful Substances*
- Other: (Specify)

**Risk 401 – (Other Dietary Risk) Risk of Inappropriate Complementary Feeding Practices Only use if no other risk is identified.**

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**Risk 400: Inappropriate Nutrition Practices. If yes, document how.**

- [ ] Yes
- [ ] No

**Primary Nutrition Contact**

**Comments:**

**Plan / Goals:**

*Sign./Title/Date: ____________________________

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**Secondary Nutrition Contact**

**Date:** __________  *Sign./Title: ____________________________

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**Secondary Nutrition Contact**

**Date:** __________  *Sign./Title: ____________________________