Nutrition Assessment
Ages 0-3

Child's Name: _____ **Date of Birth:** _____/_____/_____

Family Advocate: _____ **Date:** _____/_____/_____

Diet:

1. Is your child on a special diet? _____Yes _____ No If yes, what type? _____

_____

2. Do you need to feed your child in a special way? _____Yes _____ No If yes, explain: _____

_____

3. Do you have nutritional concerns regarding your child? ____ Yes ____ No

If yes, what and why? _____

4. Do you consider your child to be a fussy eater? _____Yes _____No

If yes, what foods, and textures does your child not eat? _____

5. Do you enjoy mealtimes together? _____

Additional Questions for children under 12 months:

6. Has your child started table foods? _____Yes _____No

7. If yes, have you noticed preferences or intolerances?

_____

8. How do you feel about the transition to table foods? _____

9. Is your child drinking: _____ breast milk or _____ formula (which type?) _____

10. Any questions/concerns on breast or bottle feeding?

Additional Notes: