



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: