

0-3 Month Nutritional Screening

Today's Date: _____ Center Name: _____
Child's Name: _____ Date of Birth: _____
Height: _____ Weight: _____ Receives WIC yes ___ no _____

Was your baby premature? _____
If yes, how many weeks early? _____

Is your baby breastfeeding now? _____ yes _____ no
If yes, approximately how many times in 24 hours? _____

Is your baby currently drinking formula? _____ yes _____ no
If yes, how many ounces at each feeding? _____

Is there anything else that your baby is currently drinking besides formula, breast milk or water? _____
If yes, please explain why: _____

Has your baby been diagnosed with any food allergies? _____ yes _____ no
If yes, please list: _____

Is your baby on a special diet? _____ yes _____ no
If yes, please describe: _____

Does your baby often have: Diarrhea? _____ yes _____ no
 Constipation? _____ yes _____ no

Do you have any nutritional concerns about your baby at this time? _____ yes _____ no
If you do please explain: _____
_____.

Parent Signature: _____ Date: _____

Staff Signature: _____ Date: _____

For Office Use Only

Weight Status _____
Nutrition Status _____
Special Diet ___ yes ___ no

N = Normal
O = Overweight
U = Underweight
R = Refer
A = At Risk
T = Under Care/Treatment

Comments: _____
_____.

Dietitian Signature: _____ Date: _____