What Does Your Child Eat?
(Ages Birth – Eight)

Circle the foods your child eats every day or at least 3 times per week:

### Baby Foods
- Breast milk
- Formula with Iron
- Cereal with Iron
- Pureed Fruit
- Pureed Vegetables
- Pureed Meat
- Eggs
- Beans
- Juice
- Sweetened Beverages
- Honey

### Bread, Grains and Cereals
- Whole Grain Bread
- White Bread
- Tortilla
- Sweet Bread
- Cereal with Iron
- Oatmeal
- Bagels
- Crackers
- Pretzels
- Noodle Soup
- Pasta
- Rice

### Fruits and Vegetables
- Apple
- Banana
- Grapes
- Pear
- Peach
- 100% Juice
- Strawberry
- Pineapple
- Orange
- Cantaloupe
- Melon
- Bell pepper
- Chili pepper
- Tomato
- Green Salad
- Cucumber
- Mango
- Broccoli
- Cabbage
- Dark Green Leafy Vegetables
- Carrot
- Green Beans
- Peas
- Corn
- Sweet Potato

### Milk Products
- Whole Milk
- 2% Milk
- 1% Lowfat milk
- Nonfat Milk
- Flavored Milk
- Lactose Free Milk
- Cheese
- Cottage Cheese
- Yogurt
- Ice Cream

### Other Food Sources of Calcium
- Beans
- Tofu
- Soy Yogurt/Milk
- Green leafy vegetables
- Calcium Fortified 100% Juice
- Fortified Plant Milk (Almond, Rice)

### Protein Foods
- Chicken/Turkey
- Beef
- Ham
- Pork
- Fish/Canned fish
- Eggs
- Tofu
- Tacos
- Meat/Beans Burritos
- Peanuts/Peanut/Nut Butters
- Beans/Lentils
- Spaghetti with Meatballs

### Other Foods
- Hot dog
- Hamburger
- Pizza
- French Fries
- Fried Chicken
- Chips
- Cheese Puffs
- Candies
- Chocolate
- Cookies

### Circle if baby/child uses
- Fluoride
- Iron Drop Vitamins
- Spoon
- Cup
- Baby bottle
- Toothbrush

### Circle if baby/child drinks
- Water
- Soda
- Sugar Sweetened Drinks
- Sports Drinks
- Juice

### Circle activities your baby or child does every day
- Crawling
- Walking
- Swinging
- Rope jumping
- Playing ball
- Riding a tricycle/bicycle
- Views TV, video games or computer more than two hours a day

### Circle if baby/child receives
- CalFresh (Food Stamps)
- School Lunch
- Head Start
- WIC

### Child's name: _____________________________  Record #:__________

### Age: _____ yrs _____ mos  Wt: _____ lbs  Ht: _____ in  Date: ___/___/___

Please circle Yes or No to answer the following questions:

**Birth to 24 months**

Does the child less than 1 year of age eat honey/corn syrup?  Yes No

0-6 months

Breastfeeding at least 8–12 times each 24 hours for first 3 months?  Yes No

Breastfeeding 6-8 times or more each 24 hours for age 4-6 months?  Yes No

Feeding formula with iron at least 20 ounces a day?  Yes No

6 to 9 months

Eats baby cereal with iron?  Yes No

Eats pureed fruits and vegetables?  Yes No

Eats pureed or ground meat, fish cooked egg yolk, beans, tofu?  Yes No

Drinks or sips from a cup?  Yes No

9 to 12 months

Eats mashed/chopped foods?  Yes No

Eats foods with fingers?  Yes No

Drinks 16 ounces whole milk a day?  Yes No

Eats a variety of different foods?  Yes No

Feeds himself (or herself)?  Yes No

Joins family meal and snack times?  Yes No

Drinks soda or other sweet drinks?  Yes No

**Other**

Does the child have food allergies or intolerances?  Yes No

Please list: _____________________________

Does the child play with or eat dirt, plaster, clay or paint chips?  Yes No

Does the child 3 years or younger eat grapes, nuts, seeds, popcorn hot dogs and/or hard candy?  Yes No

---

**Office Use Only**

Referred for identified nutrition problem?  Yes No

If yes, where: _____________________________

Provider initials: ___________________________