Child (2 - 5 years) Diet Questionnaire

Child's Name: _____ Child's Birth Date: ___/___/_____ Today's date: ___/___/_____

1. Please check all of the following you have that work. ☐Stove Top ☐Oven ☐Microwave ☐Refrigerator

2. What does your child usually drink? (Please check all that apply.)
   ☐Milk (including breastmilk) ☐Formula ☐Juice/Juice Drinks ☐Water ☐Sweetened Tea
   ☐Regular Pop/Kool-Aid ☐Herbal Teas ☐Gatorade/Sports Drinks ☐Other: _____

3. What does your child drink from? (Please check all that apply.) ☐Breast ☐Bottle ☐Sippy Cup ☐Cup

4. Does your child ever walk around drinking from a sippy cup or a bottle? ☐No ☐Yes

5. How many times does your child drink milk during a normal day? _____ ☐Child does not drink milk
   a. How much milk does your child drink each time? _____ounces
   b. What type of milk does your child usually drink?
      ☐Cow's (_____Whole (Vitamin D) _____Reduced/Low Fat (2%, 1% or ½%) _____Skim)
      ☐Lactose Free ☐Goat's ☐Evaporated ☐Sweetened Condensed ☐Soy ☐Rice
      ☐Other: _____
   c. Do you ever add any flavoring to the milk? ☐ No ☐Yes, what? _____

6. How many times does your child drink water during a normal day? _____ ☐Child does not drink water
   a. How much water does your child drink each time? _____ounces
   b. What kind of water does your child usually drink? ☐City/Rural ☐Well ☐Bottled ☐Unsure
   c. Do you ever add anything to the water? ☐No ☐Yes, what? _____

7. How many times does your child drink juice during a normal day? _____ ☐Child does not drink juice.
   a. How much juice does your child drink each time? _____ounces
   b. What kind of juice or juice drinks does your child usually drink? _____
   c. Do you dilute the juice with water? ☐No ☐Yes

8. At mealtimes, how often does your child eat the same foods as the rest of the family?
   ☐Most of the time ☐Sometimes ☐Rarely, what does your child eat? _____
   a. What types of food does your child eat? (Please check all that apply.)
      ☐Baby foods ☐ Table foods (_____ Coarsely chopped/sliced _____Mashed/blended _____Finely chopped)
   b. Can your child feed him/herself? ☐No ☐Yes

9. How many times does your child eat on a normal day? Meals _____ Snacks _____

10. What do you do when your child asks for food between meals and snacks? _____

11. Please mark the situations that describe where your child normally eats. (Check all that apply.)
    ☐In a high chair ☐At a table ☐On the sofa ☐On the floor
    ☐At home ☐In a restaurant/fast food ☐In the car ☐At childcare/Head Start/preschool
    ☐With the TV on ☐With family / friends ☐Alone ☐Other: _____

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12. Which snack foods does your child usually eat? (Please check all that apply.) ☐Child does not eat snack foods
☐Fruit ☐Fruit Snacks ☐Cookies/Snack Cakes ☐Crackers ☐Chips ☐Popcorn ☐Nuts
☐Pretzels ☐Ice Cream ☐Cereal/Cereal Bars ☐Hard Candies ☐Other _____

13. How many times does your child eat fruits and vegetables (not juice) during a normal day? _____
☐Child does not eat fruits or vegetables
Which fruits and/or vegetables does your child usually eat? (Please check all that apply.)
☐Apples/Applesauce ☐Bananas ☐Grapes ☐Oranges ☐Pears ☐Potatoes ☐French Fries
☐Corn ☐Green Beans ☐Carrots ☐Sprouts ☐Tomato ☐Other: _____

14. How many times does your child eat protein foods during a normal day? _____ ☐Child does not eat protein foods
Which protein foods does your child usually eat? (Please check all that apply.)
☐Beef/Buffalo ☐Chicken/Turkey ☐Fish/Seafood ☐Pork/Lamb ☐Hot Dogs/Lunch Meat ☐Yogurt
☐Peanut Butter ☐Eggs ☐Tofu ☐Dried/Canned Beans ☐Hard Cheese (American, Cheddar, Swiss…)
☐Soft Cheese (Feta, Brie, Blue-Veined, and Queso Fresco) ☐Other _____

15. Which sweets does your child usually eat? (Please check all that apply.) ☐Child does not eat anything sweet
☐Sugar ☐Honey ☐Syrup ☐Candy ☐Other _____
How are they usually eaten? (Please check all that apply.)
☐Added to/in drinks ☐In pre-sweetened drinks ☐On the pacifier
☐Added to/on foods ☐In sweet foods (candies, cookies, cakes etc) ☐Other _____

16. Does your child regularly eat anything that is not food, such as dirt, paper, crayons, pet food or paint chips?
☐No ☐Yes

17. Does your child have any health/medical/dental problems? ☐No ☐Yes, please list: _____
Was this problem diagnosed by a doctor? ☐No ☐Yes

18. Please check and describe all of the following your child usually takes.
☐Over-the-counter drugs (cold medicine, pain killers, etc.) _____
☐Prescription medication _____
☐Vitamin and/or minerals supplements _____
☐Herbs/Herbal Supplements (Echinacea, ginger, etc.) _____
☐Other _____

19. Do you worry about how much your child is eating? ☐No ☐Yes, please explain? _____

20. Has your child had a blood lead test? ☐ No ☐Yes ☐ Unsure
If yes, where? _____ When? ___/____/_____ What were the results? _____

21. What is one thing you like about your child's eating?_____

22. What is one thing that you would like to change about your child's eating? _____

23. How much time does your child spend actively playing each day? _____hours

24. About how many hours does your child sit and watch TV, videos, or DVDs on a normal day?
_____ hours/day ☐ child does not usually watch any TV, videos or DVDs