Child's Name: _____
Child's DOB: _____
Date: _____

WV Birth to Three Nutrition Assessment

Name of Child: _____ Age: _____

Date of Birth: _____ Adjusted Age: _____

Parents Names: _____ Date of Evaluation: _____

Address _____ Phone Number: _____

_____ County/RAU: _____

Email: _____

Purpose:

☐ To gather information to determine eligibility for WV Birth to Three and plan for Individualized Family Service Plan.

☐ Initial ☐ Annual

☐ To provide additional information to the IFSP Team regarding the following area of concern:

Mother's Health History

Smoked during pregnancy: | Yes __ No If "yes", how often? _____

Maternal drug use:: __ Yes | No If "yes", type/frequency?_____

Do caregivers smoke? | Yes __ No If "yes", where do the caregivers smoke?

☐ In a separate room ☐ Outside of the home ☐ Other, please indicate: _____

Child's Medical History

Birth History:

Birth Weight: _____ Birth Length: _____

Medical History/Medical Diagnosis

Child's Name: _____
Child's DOB: _____
Date: _____

Has there been a history of reflux/infantile posturing? ☐ Yes ☐ No If "yes", note concerns.

Hearing or Vision Concerns: ☐ Yes ☐ No If yes, please indicate:

Family Medical History/Genetics (include parents, siblings and grandparents):

Medical Technology in Use: ☐ Yes ☐ No

Were trained you on the use of the medical technology? ☐ Yes ☐ No

Would you like further training on your child's medical technology or device? ☐ Yes ☐ No

Coordination with Medical Team

Child's Primary Care Physician:

List other members of your child's medical team:

Do you receive care coordination from Children with Special Health Care Needs? ☐ Yes ☐ No

Do you have outside services coming into your home to help care with your child such as in-home nursing, respite, Title IX? ☐ Yes ☐ No

What other family and community resources support your child and family?

Have you given written permission for WV Birth to Three to consult with your child's medical team? ☐ Yes ☐ No

Do you need help discussing your concerns with your child's physician or being linked to additional training/resources? ☐ Yes No

Current Health Status:

Do you or your doctor have concerns about your child's size? ☐ Yes ☐ No.

Growth Chart Used: ☐ World Health Organization Child Growth ☐ Center for Disease Control Pediatric Chart

Head Circumference:	_____	Height:	_____	Weight	_____	BMI:	_____
Percentiles:	_____		_____		_____		_____

☐ ***SEE NUTRITION ASSESSMENT ATTACHMENT FOR GROWTH CHART.***

Child's Name: _____
Child's DOB: _____
Date: _____

Does your child have food allergies? ☐ Yes ☐ No. (*If yes, list below*)

Does your child take any medications or other supplements (vitamins, iron, fluoride, or herbal supplements) on a regular basis? ☐ Yes ☐ No. (*If yes, list below)*

Current Medications:

Vitamin Supplements:

Nutrition History

How does your child eat? Check choices below that best describe how.

- ☐ uses bottle
- ☐ breastfeeds
- ☐ takes sips from a cup
- ☐ drinks from a cup with/without lid
- ☐ uses a straw
- ☐ takes oral feeding supplements (Pediasure®, Boost®, Kindercal®, and Neocate®)
- ☐ has feeding tube
- ☐ finger feeds
- ☐ fed by spoon
- ☐ self-feeds with spoon/fork
- ☐ uses special feeding equipment, what?
- ☐ takes food other than milk from a bottle

Do you have any concerns about whether your child is eating an appropriate stage for his age?
☐ Yes ☐ No

Do you feel you have enough foods, formula for your child? ☐ Yes ☐ No

Do you have a mealtime routine that you follow with your child and family? Please explain:

Do you have concerns about your child's mealtime experiences and eating behaviors? Yes ☐ No
If yes, check the choices below

- ☐ child refuses to eat
- ☐ child spits out food
- ☐ child throws food or utensils
- ☐ child eats too slowly
- ☐ child stuffs mouth
- ☐ child takes bottle to bed
- ☐ no scheduled mealtimes
- ☐ child unable to sit through meal
- ☐ mealtimes are hectic
- ☐ meal seems to take too long
- ☐ child eats items, which are not food, (i.e. paint chips, crayons, dirt, paper, cigarettes, etc.)

Child's Name: _____
Child's DOB: _____
Date: _____

Liquids

☐ Breast Fed ☐ Formula ☐ G-Tube fed only ☐ G-Tube supplements with permission to feed by mouth

Has there been a history of formula changes? ☐ Yes ☐ No If "yes", note changes and results.

Solids

☐ Infant cereal ☐ Pureed fruits ☐ Pureed vegetables ☐ Finger Foods ☐ Table food

Amount and frequency of feedings:

Are there any known food allergies? Intolerances? ☐ Yes ☐ No If "yes", please note information here.

Are there any foods that causes your child to spit up, choke, gag or child refuses due to temperature or texture?
☐ Yes ☐ No If "yes," please indicate.

Foods removed from diet:

Favorite Foods:

Favorite Beverages:

Appetite:

Utensils used: ☐ Bottle ☐ Cups ☐ Spoon ☐ Fork

Does your child use any adaptive feeding utensils? ☐ Yes ☐ No If "yes," please indicate

Does your child require more formula over the WIC allotment? ☐ Yes ☐ No

Bowel and Bladder

If child has bowel problems, what interventions were tried in the past and did they work?

☐ Diapers Amount: ☐ Frequency: ☐ Consistency: ☐
☐ Toilet trained Amount: ☐ Frequency: ☐ Consistency: ☐

Sleep Patterns/ Activity Level

Where does your child sleep?

How do you position your child for sleep?

Does your child have a bedtime routine?

Behavioral Issues?

Developmental History?

Summary of Developmental Domains Evaluated and Developmental Scores

Domain	Test Used	Score(s)	Developmental Delay
ADAPTIVE			Choose one Item

Child's Name: _____
Child's DOB: _____
Date: _____

Established Conditions

Established Conditions Category	List Medical Condition
Choose an Item	
Choose an Item	
Choose an Item	
Choose an Item	

At-Risk Conditions

At-Risk Category	List Medical Condition
Choose an Item	
Choose an Item	
Choose an Item	
Choose an Item	
Choose an Item	

Recommendations/Information and Intervention suggestions

Contact information for Nutritionist

Name _____

Signature _____ Date: _____

Email _____ Phone _____