

Student Name: \_\_\_\_\_

Connecticut State Department of Education-2001

## Nutrition Questionnaire for Children

(Adapted from *Bright Futures in Practice: Nutrition*, Appendix B, pgs. 232-236, National Center for Education in Maternal and Child Health, 2000)

*This nutrition questionnaire is a tool for parents to complete before meeting with child care staff members (e.g., health or education professionals, family day-care providers). The questionnaire provides a useful starting point for identifying areas of nutrition concern and the need for additional screening. It may be adapted with the names of foods consumed by a specific cultural group. Note: This questionnaire is not all-inclusive, and should be adapted as necessary to meet the specific needs of individual programs.*

1. How would you describe your child's appetite? (Check one.)

- Good       Fair       Poor       Picky

2. How many days per week does your family usually eat meals together? \_\_\_\_\_

3. How would you describe mealtimes with your child? (Check one.)

- Always pleasant       Usually pleasant       Sometimes pleasant       Never pleasant

4. How many meals does your child usually eat per day? \_\_\_\_\_

5. How many snacks does your child usually eat per day? \_\_\_\_\_ : \_\_\_\_\_

6. Which of these foods did your child eat or drink last week? (Check all that apply.)

### Grains

- Bagels  
 Bread  
 Cereal/grits  
 Crackers  
 Muffins  
 Noodles/pasta  
 Rice  
 Rolls  
 Tortillas  
 Other grains:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Vegetables

- Broccoli  
 Carrots  
 Corn  
 French beans  
 Green beans  
 Green salad  
 Greens (collard, spinach)  
 Peas  
 Potatoes  
 Tomatoes  
 Other vegetables:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Fruits

- Apples/juice  
 Bananas  
 Berries  
 Grapefruit juice  
 Grapes/juice  
 Melon  
 Oranges/juice  
 Peaches  
 Pears  
 Other fruits/juice:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Nutrition Questionnaire for Children (continued)

6. Continued (Check all that apply.)

### Milk and Other Dairy Products

- Whole milk
- 2% milk (reduced-fat)
- 1% milk (low-fat)
- Skim milk (nonfat)
- Chocolate milk
- Cheese
- Ice cream
- Yogurt
- Other milk

### Meat and Meat Alternates

- Beef hamburger
- Chicken
- Cold cuts/lunchmeat
- Dried beans
- Eggs
- Fish
- butter/nuts

### Fats and Sweets-

- Cake/cupcakes
- Candy
- Chips
- Cookies
- Doughnuts
- Fruit-flavored drinks-
- Kool-Aid®
- Pie
- Soft drinks
- Other fats and sweets:

7. If your child is 5 years of age or younger; does he or she eat any of these foods? (Check all that apply.)

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Hot dogs       | <input type="checkbox"/> Popcorn            | <input type="checkbox"/> Raw celery or carrots |
| <input type="checkbox"/> Marshmallows   | <input type="checkbox"/> Pretzels and chips | <input type="checkbox"/> Round or hard candy D |
| <input type="checkbox"/> Nuts and seeds | <input type="checkbox"/> Raisins            | <input type="checkbox"/> Whole grapes          |
| <input type="checkbox"/> Peanut Butter  |   |  |

8. How much 100 percent juice (for example, orange juice, apple juice and grape juice) does your child drink per day? \_\_\_\_\_

9. How much sweetened beverage (for example, Kool-Aid®, fruit punch and soft drinks) does your child drink per day? \_\_\_\_\_

10. Does your child drink water that is fluoridated or take a fluoride supplement?

- Yes       No       Don't Know

II. Does your child take a bottle to bed at night or carry a bottle or sippy cup around during the day?

- Yes       No

12. Do you have a working stove, oven and refrigerator where you live?       Yes       No

13. Were there any days last month when your family didn't have enough food to eat or enough money to buy food?       Yes       No

14. Does your child spend more than 2 hours per day watching television and videotapes or playing computer games?       Yes       No

15. What concerns or questions do you have about feeding your child? \_\_\_\_\_