

Infant Nutrition Questionnaire

6 Months to 12 Months

CHILD'S NAME: _____ CHILD'S DOCTOR: _____ DATE: ____/____/____
MM DD YY

1. What would you like to discuss today?

2. What concerns or questions do you have about your baby?: (check all that apply)

- Eating too much or not enough
- Gaining too much weight or not enough weight
- Picky eating
- I have no concerns
- Other, please list: _____

3. My baby has a: (check all that apply)

- Food allergy: _____
- Medical issue: _____
- Other, please list: _____
- None of the above

4. My baby currently takes: (check all that apply)

- Medicine: _____
- Vitamins or minerals: _____
- Herbal teas or products: _____
- Other, please list: _____
- None of the above

5. In the past month, my baby has had: (check all that apply)

- Diarrhea
- Constipation
- Vomiting, spitting up or reflux
- None of the above

6. Tell me how breastfeeding is going:

- Really well
- I could use some help/support
- I stopped breastfeeding
- I am not breastfeeding

7. My baby eats using: (check all that apply)

- Breast
- Baby bottle
- Sippy cup or regular cup
- His or her fingers
- Spoon or fork
- Other, please list: _____

8. My baby shows me they are hungry by:

9. My baby shows me they are full by:

10. My baby eats: (check all that apply)

- Infant cereal
- Vegetables (including pureed baby food)
- Fruits (including pureed baby food)
- Meats (including pureed baby food)
- No food other than breast milk or formula
- Other foods, please list: _____

11. My baby drinks: (check all that apply)

- Breast milk
- Formula, please list name: _____
- Water
- 100% fruit juice
- Sugar-sweetened beverages (e.g., soda, sweet tea, lemonade, sports drinks, energy drinks)
- Other drinks, please list: _____

12. Within the past six months, I worried that our food would run out before I had money to buy more.

- Never true
- Sometimes true
- Often true