Infant Nutrition Assessment

Name _____ ID _____ Early Head Start: __ enrolled __ not enrolled EHS Center/Worker _____

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DOB _____	0-2 Month Age: _____ mo _____ day	3-5 Month Age: _____ mo _____ day	6-8 Month Age: _____ mo _____ day	9-12 Month Age: _____ mo _____ day
Growth	Wt _____ Length _____ W/L % _____ Y N Back to birth weight by 2 weeks	Wt _____ Length _____ W/L % _____ Y N Adequate weight gain	Wt _____ Length _____ W/L % _____ Y N Adequate weight gain	Wt _____ Length _____ W/L % _____ Y N Adequate weight gain Hgb _____
Baby is drinking	☐ Breastmilk: Freq/24 hr._____ Duration_____ Bottle: _____ oz. X ____ bottles/ 24 hrs. Diapers/day: ____ wet ____ stools ☐ Formula: Name _____ Offered in: ___ bottle ___ cup Amount: _____ oz. X ____ bottles/ 24 hrs. ☐ Juice: Type _____ Offered in: ___ bottle ___ cup Amount: ____ - ____ ounces every 24 hours ☐ Other: _____ Offered in: ___ bottle ___ cup Amount: ____ - ____ ounces every 24 hours	☐ Breastmilk: Freq/24 hr._____ Duration_____ Bottle: _____ oz. X ____ bottles/ 24 hrs. ☐ Formula: Name _____ Offered in: ___ bottle ___ cup Amount: _____ oz. X ____ bottles/ 24 hrs. ☐ Juice: Type _____ Offered in: ___ bottle ___ cup Amount: ____ - ____ ounces every 24 hours ☐ Other: _____ Offered in: ___ bottle ___ cup Amount: ____ - ____ ounces every 24 hours Y N Bottle in bed	☐ Breastmilk: Freq/24 hr._____ Duration_____ Bottle: _____ oz. X ____ bottles/ 24 hrs. ☐ Formula: Name _____ Offered in: ___ bottle ___ cup Amount: _____ oz. X ____ bottles/ 24 hrs. ☐ Juice: Type _____ Offered in: ___ bottle ___ cup Amount: ____ - ____ ounces every 24 hours ☐ Other: _____ Offered in: ___ bottle ___ cup Amount: ____ - ____ ounces every 24 hours Y N Bottle in bed	☐ Breastmilk: Freq/24 hr._____ Duration_____ Bottle: _____ oz. X ____ bottles/ 24 hrs. ☐ Formula: Name _____ Offered in: ___ bottle ___ cup Amount: _____ oz. X ____ bottles/ 24 hrs. ☐ Juice: Type _____ Offered in: ___ bottle ___ cup Amount: ____ - ____ ounces every 24 hours ☐ Other: _____ Offered in: ___ bottle ___ cup Amount: ____ - ____ ounces every 24 hours Y N Bottle in bed
Baby is eating	☐ No solid food ☐ Cheese/yogurt ☐ Cereal __ bottle __ spoon ☐ Meats/poultry/eggs ☐ Fruits/Veg. ☐ Beans/peas ☐ Bread/rice/crackers ☐ Desserts ☐ Mixed dinners ☐ Other _____	☐ No solid food ☐ Cheese/yogurt ☐ Cereal __ bottle __ spoon ☐ Meats/poultry/eggs ☐ Fruits/Veg. ☐ Beans/peas ☐ Bread/rice/crackers ☐ Desserts ☐ Mixed dinners ☐ Other _____	☐ No solid food ☐ Cheese/yogurt ☐ Cereal __ bottle __ spoon ☐ Meats/poultry/eggs ☐ Fruits/Veg. ☐ Beans/peas ☐ Bread/rice/crackers ☐ Desserts ☐ Mixed dinners ☐ Other _____	☐ No solid food ☐ Cheese/yogurt ☐ Cereal __ bottle __ spoon ☐ Meats/poultry/eggs ☐ Fruits/Veg. ☐ Beans/peas ☐ Bread/rice/crackers ☐ Desserts ☐ Mixed dinners ☐ Other _____
Feeding Dynamics	Hunger cues: ☐ Crying ☐ Sucking ☐ Rooting ☐ Sounds/movement Satiety cues: ☐ Sleeps ☐ Turns away ☐ Fussy ☐ Stops sucking Y N Baby is held when fed Y N Cues are followed	☐ Sits in high chair ☐ No tongue thrust ☐ Shows interest in food ☐ Opens mouth for spoon *Cereal Assessment* Y N Baby is ready Y N Baby is held when fed Y N Cues are followed	Y N Offered solid foods 2-3 times each day Y N Offered liquid in a regular, open-mouth cup Y N Offered finger foods Y N Baby is held when fed Y N Cues are followed	Y N Offered solid foods at family meals 3x/day Y N Offered liquid in a regular, open-mouth cup Y N Offered finger foods Y N Baby is held when fed Y N Cues are followed
Feeding–Related Problems	☐ Cough/gag/choke ☐ Sucking problems ☐ Swallowing problems ☐ Constipation ☐ Reflux (GERD) ☐ Diarrhea ☐ Other _____ ☐ None	☐ Cough/gag/choke ☐ Sucking problems ☐ Swallowing problems ☐ Constipation ☐ Reflux (GERD) ☐ Diarrhea ☐ Other _____ ☐ None	☐ Cough/gag/choke ☐ Sucking problems ☐ Swallowing problems ☐ Constipation ☐ Reflux (GERD) ☐ Diarrhea ☐ Other _____ ☐ None	☐ Cough/gag/choke ☐ Sucking problems ☐ Swallowing problems ☐ Constipation ☐ Reflux (GERD) ☐ Diarrhea ☐ Other _____ ☐ None
Medicines & Supplements	☐ Vitamins/Minerals ☐ Fe supp. ☐ Herbs (tea, mixtures) ☐ Fluoride ☐ Other _____ ☐ None ☐ Medicines _____	☐ Vitamins/Minerals ☐ Fe supp. ☐ Herbs (tea, mixtures) ☐ Fluoride ☐ Other _____ ☐ None ☐ Medicines _____	☐ Vitamins/Minerals ☐ Fe supp. ☐ Herbs (tea, mixtures) ☐ Fluoride ☐ Other _____ ☐ None ☐ Medicines _____	☐ Vitamins/Minerals ☐ Fe supp. ☐ Herbs (tea, mixtures) ☐ Fluoride ☐ Other _____ ☐ None ☐ Medicines _____
Dental Care	Gums are washed or brushed: ☐ every day ☐ every few days ☐ never	Gums/teeth are washed or brushed: ☐ every day ☐ every few days ☐ never	Gums/teeth are washed or brushed: ☐ every day ☐ every few days ☐ never	Gums/teeth are washed or brushed: ☐ every day ☐ every few days ☐ never
Identified Topics	1. _____ 2. _____ 3. _____	1. _____ 2. _____ 3. _____	1. _____ 2. _____ 3. _____	1. _____ 2. _____ 3. _____
Parent–Identified Plan	1. _____ 2. _____ H.O._____	1. _____ 2. _____ H.O._____	1. _____ 2. _____ H.O._____	1. _____ 2. _____ H.O._____
Staff / Date	Staff _____ Date _____	Staff _____ Date _____	Staff _____ Date _____	Staff _____ Date _____

DTaP Dates:

1. _____
2. _____
3. _____

Referrals

_____
_____
_____
_____
_____
_____
_____
_____

Remind parents to request 12-month lead test.

Nutrition Care Plan (SOAP Note Format)

Date _____ Age_____	Date _____ Age_____	Date _____ Age_____
Staff _____ Date _____	Staff _____ Date _____	Staff _____ Date _____
Date _____ Age_____	Date _____ Age_____	Date _____ Age_____
Staff _____ Date _____	Staff _____ Date _____	Staff _____ Date _____

Baby's Name_____ Birth Date _____

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- Baby's Physician _____
- Baby's health insurance: ☐ MaineCare ☐ None ☐ Other _____
- What services does your baby currently receive?
  ☐ TANF ☐ Food Stamps
  ☐ Healthy Families ☐ Child Care
  ☐ Public Health Nursing ☐ Early Head Start

	Yes	No
• Was your baby born before 37 weeks? If yes, how many weeks early? _____	☐	☐
• Did your baby need any special care while in the hospital? If yes, please explain: _____	☐	☐
• Does your baby have any medical problems? If yes, please explain: _____	☐	☐
• Does your baby live in or spend time in a home built before 1978?	☐	☐
If yes, is the home being remodeled?	☐	☐
• Is your baby around people who smoke cigarettes, pipes, or cigars?	☐	☐
• Were there any days last month when your family did not have enough food to eat or enough money to buy food?	☐	☐
• Would you like information on places you can get food in your area?	☐	☐
• Does your drinking water come from a well?	☐	☐
• Is your baby Hispanic or Latino?	☐	☐

- What best describes your baby's race? **(check all that apply)**
  ☐ White ☐ American Indian or Alaska Native
  ☐ Black or African American ☐ Asian ☐ Native Hawaiian or Pacific Islander
- What questions do you have about feeding your baby or about how your baby is growing?

_____

Office Use Only:	Updated on _____ Staff initials _____	Updated on _____ Staff initials _____	Updated on _____ Staff initials _____	Updated on _____ Staff initials _____