

## 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 1/2%) \_\_\_\_ 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: \_\_\_\_\_

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, please list: \_\_\_\_\_
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