

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 ½%) ____ 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 Dried Beans
 Peanut Butter Eggs Tofu Yogurt 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

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