State of California—Health and Human Services Agency
Department of Health Care Services

JENNIFER KENT
DIRECTOR

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May 1, 2017

CHDP Provider Information Notice No.: 17–02

TO: ALL COUNTY CHILD HEALTH AND DISABILITY PREVENTION (CHDP) PROGRAM DIRECTORS, DEPUTY DIRECTORS, PUBLIC HEALTH NURSES, NUTRITIONISTS, HEALTH EDUCATORS AND PROGRAM PROVIDERS AND MANAGED CARE PLANS

SUBJECT: REVISION OF THE FOOD SCREENING FORM "WHAT DOES YOUR CHILD EAT? BIRTH TO 8 YEARS" AND "WHAT DO YOU EAT? AGES 8-19 YEARS"

The purpose of this CHDP Provider Information Notice is to inform providers of the revised English version of the food screening form "What Does Your Child Eat? Birth to 8 Years" and "What Do You Eat? Ages 8-19 Years".

Good nutrition is important to achieving normal growth and development, and the goal of the food screening forms, revised by the CHDP Statewide Nutrition Subcommittee is to assist CHDP Program providers and staff members during a Health Assessment. The screening forms help to identify concerns about eating and physical activity for the CHDP client from birth to eight (8) years, and eight (8) to nineteen (19) years of age.

These revised forms complement other provider tools and training modules for nutrition and growth assessment, anticipatory guidance, and referral procedures available on the CHDP Training web page at:

http://www.dhcs.ca.gov/services/chdp/Pages/Training.aspx

- Using the WHO Growth Charts to Assess Children from Birth to 2 Years
- How to Accurately Weigh and Measure Children for the CHDP Well Child Exam
- Body Mass Index (BMI) Training
- Promoting Physical Activity at Well Child Visit Training Module
- Glucose and Cholesterol Screening for Pediatric Obesity

If you have questions about these or other nutrition and growth assessment training tools, please contact Carol Hazell at (916) 323-8010 or via e-mail at Carol.Hazell@dhcs.ca.go.

Sincerely,

ORIGINAL SIGNED BY PATRICIA McCLELLAND

Patricia McClelland, Chief
Systems of Care Division

Attachments

What Does Your Child Eat?

(Ages Birth – Eight)

Circle the foods your child eats every day or at least 3 times per week:

Baby Foods

Breast milk Formula with Iron Cereal with Iron
Pureed Fruit Pureed Vegetables Pureed Meat Eggs Beans
Juice Sweetened Beverages Honey

Breads, Grains and Cereals

Whole Grain Bread White Bread Tortilla Sweet Bread
Cereal with Iron Oatmeal Bagels Crackers Pretzels
Noodle Soup Pasta Rice

Fruits and Vegetables

Apple Strawberry Grapes Pear Peach 100% Juice
Pineapple Orange Banana Melon Mango Cantaloupe
Bell pepper Chili pepper Tomato Potato Cucumber Peas
Broccoli Green Salad Cabbage Corn Green Beans
Carrots Sweet Potato Dark Green Leafy Vegetables

Milk Products

Whole Milk 2% Milk 1% Lowfat milk Nonfat Milk
Flavored Milk Cottage Cheese Lactose Free Milk Cheese
Yogurt Ice Cream

Other Food Sources of Calcium

Beans Tofu Soy Yogurt/Milk Green leafy vegetables
Calcium Fortified 100% Juice Fortified Plant Milk (Almond, Rice)

Protein Foods

Chicken/Turkey Meat/Beans Burritos Ham/Pork Tacos
Beans/Lentils Peanuts/Peanut/Nut Butters Tofu Beef
Fish/Canned fish Spaghetti with Meatballs Eggs

Other Foods

Hot dog Hamburger Pizza French Fries Fried Chicken
Chips Cheese Puffs Candies Chocolate Cookies

Circle if baby/child uses

Fluoride Iron Drop Vitamins
Spoon Cup Baby bottle Toothbrush

Circle if baby/child drinks

Water Soda Sugar Sweetened Drinks Sports Drinks Juice

Circle activities your baby or child does every day

Crawling Walking Swinging Rope jumping
Playing ball Riding a tricycle/bicycle
Views TV, video games or computer more than two hours a day

Circle if baby/child receives

CalFresh (Food Stamps) School Lunch Head Start WIC

Child's name: _____ Record #:_____

Age: ____ yrs ____ mos **Wt:** _____ lbs **Ht:** _____ in **Date:** ___/___/___

Please circle **Yes** *or* **No**
to answer the following questions:

Birth to 24 months

Does the child less than 1 year of age eat honey/corn syrup? **Yes No**

0-6 months

Breastfeeding at least 8–12 times each 24 hours for first 3 months? **Yes No**
Breastfeeding 6-8 times or more each 24 hours for age 4-6 months? **Yes No**
Feeding formula with iron at least 20 ounces a day? **Yes No**

6 to 9 months

Eats baby cereal with iron? **Yes No**
Eats pureed fruits and vegetables? **Yes No**
Eats pureed or ground meat, fish, cooked egg yolk, beans, tofu? **Yes No**
Drinks or sips from a cup? **Yes No**

9 to 12 months

Eats mashed/chopped foods? **Yes No**
Eats foods with fingers? **Yes No**

1 to 2 years

Drinks 16 ounces whole milk a day? **Yes No**
Eats a variety of different foods? **Yes No**
Feeds himself (or herself)? **Yes No**
Joins family meal and snack times? **Yes No**
Drinks soda or other sweet drinks? **Yes No**

Other

Does the child have food allergies or intolerances? **Yes No**
Please list: _____
Does the child play with or eat dirt, plaster, clay or paint chips? **Yes No**
Does the child 3 years or younger eat grapes, nuts, seeds, popcorn, hot dogs and/or hard candy? **Yes No**

OFFICE USE ONLY

Referred for identified nutrition problem? **Yes No**
If yes, where: _____
_____
Provider initials: _____

Adapted from the CHDP Programs of Orange and San Bernardino Counties
DHCS 4035 A (05/16)

What Do You Eat?

(Ages 8-19)

Circle the names of foods you eat often:

Iron/Protein

Chicken/Turkey	Ham/Pork	Seafood	Eggs	Tofu
Hamburger	Fried Chicken	Tacos	Peanut	Pizza
Whole Grain Bread	Peanut Butter	Cereal	Rice	Hot dog
Meat/Bean Burrito	Noodle Soup	Tortilla	Beef	Pasta
Sweet Bread	Beans/Lentils	White Bread		Potato
Dark Green Leafy Vegetables		Spaghetti with Meatballs		

Fruits and Vegetables

Cucumber	Broccoli	Banana	100% Juice	Pear	Pea
Pineapple	Bell pepper	Orange	Carrots	Apple	Mango
Cantaloupe	Chili Pepper	Tomato	Grapes	Potato	Corn
Green Salad	Cabbage	Green Beans		Peach	Melon
Strawberry	Dark Green Leafy Vegetables			Sweet Potato	

Snack

Chocolate	French Fries	Fruit Pie	Donut	Candies
Vegetables	Cheese Puffs	Chips	Cookies	Bagels
Mexican Bread	Popcorn	Pretzels	Crackers	Fruits

Drinks

Sports Drinks	100% Fruit Juice	Wine	Soda
Alcoholic Drink	Flavored Drinks	Coffee	Beer
Sweetened Tea	Wine Cooler	Herbal Tea	Tea
Fruit Flavored Soda	Coffee Drink	Energy Drinks	Water

Calcium

Almond butter	Nonfat Milk	Whole Milk	2 % Milk	Prunes
1 % Lowfat Milk	Tempeh	Tahini	Yogurt	Beans
Lactose Free Milk	Ice Cream	Dried Figs	Cheese	Tofu
Cottage Cheese	Milkshake	Soy Beans	Almonds	Corn
Green Leafy Vegetables		Orange	Tortilla	
Calcium Fortified 100% Juice		Calcium Fortified Soy/Plant Milk		

Name: _____ Age: _____ Date of Birth: _____

Wt: _____ lbs **Ht:** _____ in **BMI:** _____ **BMI %ile:** _____ **Date:** _____

Office use only:

Circle to indicate the topics discussed:

Healthy eating
Regular meals/snacks
Importance of breakfast
Inadequate food supply
Low fat dairy foods
High sugar foods
Other: _____

Iron/Protein

2-3 servings daily
High iron foods
Plant protein sources such as beans, peas, lentils, nuts, etc.
Limit high fat foods

Fruits and Vegetables

2-4 fruits daily or more
3-5 vegetables daily or more
Vitamin C sources
Vitamin A sources

Calcium

3-4 servings dairy foods/day
Nonfat or 1 % milk
Lowfat dairy choices
Low lactose alternative
Calcium fortified foods
Other food sources of calcium

Snacks

High-sugar snacks
High-fat snacks
Fruit/vegetable snacks
Fast foods

Drinks

< 8-12 oz/day 100% juice
6-8 glasses of water (8 ounces each)/day
Sweetened drinks
Alcohol/caffeine

Referred for identified nutrition problem? Yes No

If yes, where: _____

Provider initials: _____

Youth Nutrition and Activity Assessment

(Ages 8 - 19)

Provide additional information about your food, activity and habits:

Eating Habits

Do you eat or drink the following meals? Circle one answer per meal.

Breakfast	**Always**	**Usually**	**Occasionally**	**Never**
Morning snack	**Always**	**Usually**	**Occasionally**	**Never**
Lunch	**Always**	**Usually**	**Occasionally**	**Never**
Afternoon snack	**Always**	**Usually**	**Occasionally**	**Never**
Dinner	**Always**	**Usually**	**Occasionally**	**Never**
Evening Snack	**Always**	**Usually**	**Occasionally**	**Never**

Exercise/Physical Activity

How many hours a day do you?

Watch TV	_____ hours/day
Use a smart phone	_____ hours/day
Play video/computer games	_____ hours/day
Use the internet	_____ hours/day

Do you participate in physical education classes at school? **Yes** **No**

Circle all that you participate in:

Walking	Running	Bicycling	Swimming
Dance	Yoga	Martial Arts	Rollerblading
Basketball	Softball	Soccer	Volleyball

Other activities or team sports: _____

How often are you physically active?

_____ times/week _____ minutes/day

Weight/Body Image

Circle one. Are you trying to?

Stay the same Lose weight Gain weight Not concerned

Do you eat less to control your weight? **Yes** **No**

Explain: _____

Have you ever made yourself vomit? **Yes** **No**

If yes, how often? _____ When was the last time? _____

Do you ever "binge" eat? **Yes** **No**

If yes, how often? _____ When was the last time? _____

Circle any of the following that you use:

Diet pills	Laxatives		
Multivitamins	Calcium	Iron	Vitamin D
Protein powder	Nutrition supplements		Steroids

What, if any, other products do you use?

Explain: _____

Office use only

Complete assessment below using all information provided:

Eating Habits

Overall diet adequate	**Yes**	**No**
3 meals and snacks	**Yes**	**No**
High iron foods	**Yes**	**No**
Calcium foods	**Yes**	**No**
5 or more fruits/vegetables	**Yes**	**No**
Adequate fluids	**Yes**	**No**

Exercise/Physical Activity

Limits use of TV, phone, internet, video or computer games to ≤ 1-2 hours/day **Yes** **No**

Goal set: _____

Engages in physical activity (60 minutes/day or more) **Yes** **No**

Goal set: _____

Referral made **Yes** **No**

Referred to: _____

Weight/Body Image

BMI %ile _____ Date _____

- ☐ ***BMI between 5th and 85th %iles***
- ☐ ***BMI ≤ 5th %ile***
- ☐ ***BMI between 85th and 95th %iles***
- ☐ ***BMI ≥ 95th %ile***

Signs of eating disorder **Yes** **No**

Counseling given **Yes** **No**

Topics: _____

Goal set: _____

Referral made **Yes** **No**

Referred to: _____