Project Head Start: Dietary Habits

HEAD START CHILD: ______________________ Classroom/Center ______________

What foods does your child especially like? ______________________

Are there any foods your child dislikes? ______________________

Does your child have any **food allergies**? ______________________

Yes response to questions marked with a star (*) may require follow-up: Add details for comments here:

	Question	Yes	No	Comments
	Does your child take vitamins and mineral supplements?	☐	☐	
	If yes, what kind are they?			______
	Do they contain iron?	☐	☐	
	Do they contain fluoride?	☐	☐	
	Were they prescribed?	☐	☐	
*	Is there any food your child should not eat for medical, religious or personal reasons?	☐	☐	______
*	Is your child on a special diet?	☐	☐	
	If yes, what kind?			______
*	Has there been a big change in your child's appetite in the last month?	☐	☐	______
*	Does your child take a bottle?	☐	☐	______
*	Does your child eat or chew things that aren't food?	☐	☐	______
*	Does your child have trouble chewing or swallowing?	☐	☐	______
	Does your child often have:			
*	Diarrhea?	☐	☐	______
*	Constipation?	☐	☐	______
*	Do you have any concerns about what your child eats?	☐	☐	______

About how often does your child eat a food from each of the following groups?

Approximate number of times each week (check number nearest to the parent's answer.)

	0	1	2	3	4	5	6	7	7+
A. Milk, cheese, yogurt	☐	☐	☐	☐	☐	☐	☐	☐	☐
B. Meat, poultry, fish, eggs; or dried beans/peas, peanut butter	☐	☐	☐	☐	☐	☐	☐	☐	☐
C. Rice, grits, bread, cereal, tortillas	☐	☐	☐	☐	☐	☐	☐	☐	☐
D. Greens, carrots, broccoli, winter squash, pumpkin, sweet potatoes	☐	☐	☐	☐	☐	☐	☐	☐	☐
E. Oranges, grapefruit, tomatoes (fruit/juice)	☐	☐	☐	☐	☐	☐	☐	☐	☐
F. Other fruits and vegetables	☐	☐	☐	☐	☐	☐	☐	☐	☐
G. Oil, butter, margarine, lard	☐	☐	☐	☐	☐	☐	☐	☐	☐
H. Cake, cookies, sodas, fruit drinks, candies	☐	☐	☐	☐	☐	☐	☐	☐	☐

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Head Start Staff ______________________ Date: ___/___/___

White copy to the office
Yellow copy to teacher