24-Hour Dietary Recall and Assessment for Children 1 Through 4 Years

Name _____

DOB _____ **Age** _____

SSN/Record No. _____

Required for Child Health

Medical Risks

*Is child underweight or overweight, or does child have poor growth? ☐ Yes ☐ No

If yes, list: _____

*Does child have anemia? ☐ Yes ☐ No

*Does child have lead poisoning? ☐ Yes ☐ No

*Does child have chronic vomiting, diarrhea, or constipation? ☐ Yes ☐ No

If yes, list: _____

Resources

Working stove and refrigerator? ☐ Yes ☐ No

☐ WIC ☐ Food Stamps

☐ Meals in child care ☐ Head Start

☐ Summer food program ☐ Food pantry or soup kitchen

Do you need help in obtaining food? ☐ Yes ☐ No

Feeding Skills

Is child weaned from bottle by 18 months? ☐ Yes ☐ No

Is child able to feed self after 2 years? ☐ Yes ☐ No ☐ N/A

*Does child have any feeding problems? ☐ Yes ☐ No

Check all that apply:

☐ sucking ☐ chewing ☐ choking

☐ swallowing ☐ gagging ☐ other (specify): _____

Dietary Practices

*Is child on a therapeutic or special diet? ☐ Yes ☐ No

If yes, describe: _____ Prescribed by: _____

*Any major food allergies? ☐ Yes ☐ No

If yes, list: _____ Symptoms: _____

*Any food groups refused or omitted? ☐ Yes ☐ No

If yes, list: _____

Does child eat dirt, clay, paint chips, or other non-foods? ☐ Yes ☐ No

Does child under 3 eat hot dogs, grapes, nuts, popcorn, or hard candies? ☐ Yes ☐ No ☐ N/A

Does child or family eat or avoid any special foods for religious or health reasons? ☐ Yes ☐ No

If yes, describe: _____

Health Habits

Hours of TV per day: _____

How many minutes per day is child physically active? _____

What type of activity? _____

How many meals given daily? _____

Are meals eaten with family? ☐ Yes ☐ No

Are snacks given? ☐ Yes ☐ No

If yes, list: _____

How many snacks per day, including beverages such as fruit juice, fruit drinks, or sodas? _____

How often do you brush and floss child's teeth? _____

Encouraged to clean plate? ☐ Yes ☐ No

Vitamin/mineral pills? ☐ Yes ☐ No

If yes, list brand or type: _____

*If yes to any of these questions, complete a 24-hour dietary recall.

Recall taken by: _____

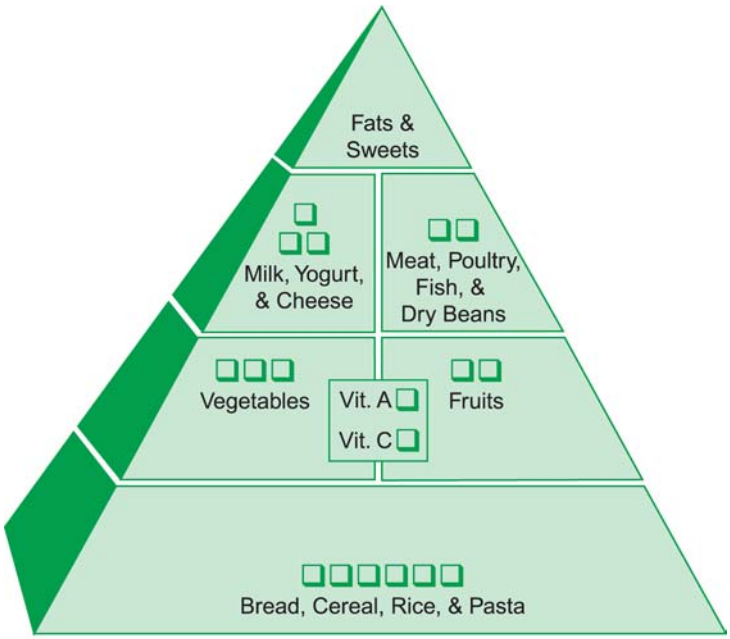
Recall assessed by: _____ **Date:** _____

ProtectTexas™ Texas Department of Health

Nutrition Education

- ☐ weaning from bottle
- ☐ feeding skills
- ☐ pica / lead poisoning
- ☐ foods that cause choking
- ☐ obesity prevention/treatment
- ☐ healthy snacks
- ☐ dental health
- ☐ healthy diet
- ☐ low-fat eating (> 2 yrs.) for heart health
- ☐ whole milk only (< 2 yrs.)
- ☐ iron-rich foods
- ☐ physical activity
- ☐ GI disturbances
- ☐ inadequate/excessive intake of: _____
- ☐ other: _____

Date: _____ Counseled by: _____



Minimum Servings

List all foods and beverages consumed in the past 24 hours or previous day.	Amount Consumed