Early Learning Center
Nutrition Assessment

Dear Parent:

Nutrition is a very important part of our program. Please take the time to fill out this questionnaire providing us with the needed information. This information will also help obtain an overview of the eating habits of children by age group.

Name: _____Age:_____ Sex: _____Date: ____/____/____

1. How many days a week does your child eat the following meals or snacks?

   A morning meal _____ a mid-afternoon snack _____

   A lunch or mid-day meal _____ an evening snack _____

   An evening meal _____ snack during the night _____

   a mid-morning snack _____

2. When is your child most hungry? _____ Morning _____ noon _____evening

3. What foods does your child dislike?_____

   _____

4. Is your child on a diet? Yes _____ No _____

   If yes, why_____

   Describe diet: _____

   Diet prescribed by whom? _____

5. Does your child eat things not usually considered food (i.e. paste, dirt, paper)? _____ Yes _____ No

   If yes, how often?: _____

   What is eaten?: _____

6. Is your child taking a vitamin or mineral supplement?: _____ Yes _____ No

   If yes, what kind?: _____

7. Does your child have any dental problems that might create a problem when eating certain foods? If yes, what?_____

8. Has your child ever been treated by a dentist? _____ Yes _____ No

9. If yes, dentist visit: ____/____/____

10. Does your child have any diet-related health problems?

    _____ Diabetes _____ Allergies _____ Other (Explain): _____

11. Is your child taking any medication for a diet-related health problem?

    ___ Yes ___ No

12. How much water does your child normally drink throughout the day? _____