Ohio Department of Health | OHIO WIC Women, Infants, and Children Program | Grow Together Breastfeed

Complete frontside ONLY

Child Health Assessment

Date(s): _____ **Child's Name:** _____

Parent/Guardian Name: _____ **Relationship:** _____

Child Health History Questions *(please complete all questions on this side – leave the backside blank)*

Where does your child go for healthcare? Doctor/clinic name: _____

Does your child attend well visits? ☐ Yes ☐ No

Is your child up to date on shots? ☐ Yes ☐ No ☐ I don't know

Does your child receive any therapy or other services? ☐ Physical ☐ Occupational ☐ Speech

☐ Home visiting: _____ ☐ Other: _____ ☐ N/A

Does your child have any medical conditions, or recent surgery, illness, food allergies, or injury? Please describe:

_____

Please list any medication(s) your child takes: _____ ☐ N/A

Is your child tube fed? ☐ Yes, Please describe:_____ ☐ No

Does your child have: ☐ Constipation ☐ Diarrhea ☐ Vomiting ☐ N/A

Has anyone in your family been tested for lead? ☐ Yes (levels): _____ ☐ No ☐ I don't know

Do you or your dentist have any dental concerns? ☐ Yes _____ ☐ No ☐ I don't have a dentist

Do you live in a temporary place (shelter, hotel, etc.)? ☐ Yes ☐ No

Has your child entered foster care or moved foster care homes, within the past six months? ☐ Yes ☐ No

Has your child been physically, verbally, sexually abused, or neglected? ☐ Yes ☐ No

Do you worry about running out of food? ☐ Yes ☐ No

Do you use local food banks/pantries? ☐ Yes ☐ No

What questions or concerns do you have about your child's health, eating habits, and breastfeeding?