

**New Jersey Department of Health and Senior Services
Child and Adolescent Health Program
PO Box 364
Trenton, NJ 08625-0364**

NUTRITIONAL ASSESSMENT
(to be used at subsequent home visits)

Name of Baby/Child	Age
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Nutritional Assessment	
Do you have food available for the family all days of the month?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Does your child have a good appetite?	<input type="checkbox"/> Yes <input type="checkbox"/> No
How many meals does your child eat each day? _____	
How many snacks? _____	
Does your child eat at school/daycare?	<input type="checkbox"/> Yes <input type="checkbox"/> No
How many meals? _____	
Does your child eat at fast food restaurants?	<input type="checkbox"/> Yes <input type="checkbox"/> No
How often? _____	

Record the frequency with which the child eats the following foods:	Daily	Weekly	Never
Milk Products:			
Cheese, Yogurt			
Whole Milk			
Skim or Low-fat Milk			
Breast Milk			
Formula			
Meat and Beans:			
Chicken, Beef, Pork, Poultry			
Fish and Shellfish			
Eggs			
Dried Beans, Peas, Peanut Butter			
Grains:			
Bread, Crackers, Cereal, Macaroni, Spaghetti, Tortillas, Pasta			
Fruits:			
Fruit, Fruit Juice			
Vegetables:			
Vegetables			
Potatoes			
Other:			
Soft Drinks			
Pastries, Ice Cream, Desserts			
Candy			
Chips, Snacks or Other High-fat Foods			