

WIC Nutrition/Health Assessment - Postpartum Woman

Name: _____ Date of Birth: _____ Today's Date: _____

1. Do you take daily vitamins or minerals?

☐ Yes ☐ No

If yes, do you take as directed?

☐ Yes ☐ No ☐ Unsure

Does your supplement contain folic acid?

☐ Yes ☐ No ☐ Unsure

Does your supplement contain iodine?

☐ Yes ☐ No ☐ Unsure

Do you take herbal or botanical supplements?

☐ Yes ☐ No

2. Do you eat/crave non-food items like clay, paint, dirt, or ice? ☐ Yes ☐ No

3. Do you have a hard time chewing or eating certain foods? ☐ Yes ☐ No

4. Do you feel you have enough food to feed your family? ☐ Yes ☐ No

5. Are you on a special diet to lose weight? ☐ Yes ☐ No

6. Have you used starvation, diet pills, laxatives, or vomiting to lose weight in the past 12 months?
☐ Yes ☐ No

7. Have you ever had weight loss surgery? ☐ Yes ☐ No

8. During any pregnancy, did you have either of the following? (select all that apply):
☐ Gestational diabetes ☐ Preeclampsia

9. What health issues do you have?

10. What recent surgery (including C-section) or injury have you had?

_____ Date: _____

We ask the following questions to better understand your most recent pregnancy and provide appropriate care. Some questions may feel personal or sensitive - please take your time, and you may skip any question you prefer not to answer.

11. Did you experience a miscarriage or a pregnancy loss at or after 20 weeks (stillbirth)? ☐ Yes ☐ No

12. Was your baby born alive but passed away within the first 28 days after birth? ☐ Yes ☐ No

13. Did any of the following apply to your most recent pregnancy? (select all that apply):

☐ Baby weighed 5 pounds 8 ounces or less at birth

☐ Baby weighed 9 pounds or more at birth

☐ Baby diagnosed with a congenital condition (such as neural tube defect, cleft palate/lip, etc.)

☐ Baby born at 38 weeks or earlier

☐ None of the above

14. Are you currently breastfeeding or making milk?

☐ Yes ☐ No

What questions do you have, if any?

15. What would you like to discuss or learn more about today?

☐ Healthy eating

☐ Physical activity

☐ Achieving a healthier weight

☐ Mental health resources or referrals

☐ Other: _____

For Staff Use Only

What are your mealtimes like? What would you like to change about your eating? What do you want to eat more or less of? If breastfeeding: Tell me how breastfeeding and/or pumping is going.

This institution is an equal opportunity provider.