PREGNANT INTERVIEW

Name/Participant ID:

Assessed By: **Date:**

HEALTH/MEDICAL

1a. **How is your pregnancy going?**

Listen, ask, and assess for

- *Obtaining prenatal care*
- *Nausea/Vomiting*
- *Heartburn*
- *Constipation*
- *Previous Pregnancies*

☐ 301 Hyperemesis Gravidarum

☐ 335 Multi-fetal Gestation

1b. **____Number of babies this pregnancy**

***1c.** **Is this your first pregnancy?** ☐ Yes ☐ No

____*Number of previous pregnancies

____*Number of live births

____Number of pregnancies past 20 weeks/5 months

Date of last birth/abortion/miscarriage: _____

1d. **With any past pregnancy, did you have any complications?**

☐ 303 – Hx of gestational diabetes
☐ 311 – Hx of preterm delivery <37 wks
☐ 312– Hx of Low Birth Weight infant <5.5 lbs
☐ 339– Hx of congenital birth defects
☐ 345 – Hx of hypertension – chronic or pregnancy induced
☐ 304 – Hx of preeclampsia
☐ 321 – Hx of miscarriage, spontaneous abortion,neonatal loss

1e. **How are you feeling this week?**

Listen, ask, and assess for

- *Nausea*
- *Vomiting*
- *Discomfort*

How do you feel about your weight gain?

☐ 301– Hyperemesis Gravidarum
☐ 302– Gestational Diabetes

***1f.** **Have you been to the doctor yet?** ☐ Yes ☐ No

*Care began after 13 weeks ☐ Yes ☐ No

1g. **Tell me about any medical problems or illnesses you have. Has your doctor diagnosed any medical problems?** ☐ Yes ☐ No

Listen, ask, and assess for

- *Medical conditions (previous to pregnancy)*
- *Health concerns*
- *Disability*
- *Illness*

1h. **Are you currently taking any medication?** ☐ Yes ☐ No

1j. **Do you ever have a hard time chewing or eating certain foods?**

Listen, ask, and assess for

- *Oral health care/Referral*
- *Tooth decay*
- *Tooth loss*
- *Impaired ability to eat*
- *Gingivitis*

☐ 381– Dental Problems

NUTRITION PRACTICES

2a. **Tell me what you like to eat and drink.**

Listen, ask, and assess for

- *Appetite*
- *Timing of meals*
- *Meals, snack, and drinks*
- *Eating pattern*
- *Frequency*
- *Eating problems*
- *Food preparation*
- *Food likes and dislikes*
- *Pica*

2b. **What would you like to change about your eating?**

2c. **Is there anything you would like to eat more or less of?**

***2d. In the month before you became pregnant with this baby, how many times a week did you take a multi vitamin?**

☐ 1x/week
☐ 2x/week
☐ 3x/week
☐ 4x/week
☐ 5x/week
☐ >7x/week
☐ Unknown

***2e. Have you taken any vitamins/minerals in the past month?**

☐ Yes ☐ No ☐ Unknown

2f. Do you take any herbs or dietary supplements now?

☐ Yes ☐ No ☐ Unknown

Nutrition Practices:

☐ 427a – consuming supplements with harmful consequences
☐ 427b – consuming diet low in calories
☐ 427c – compulsively ingesting non-food items (pica)
☐ 427d – inadequate vitamin/mineral supplementation
☐ 425e – Ingesting potentially harmful foods (Food Safety)
☐ 353– Food allergy: wheat, corn, soy, peanuts, eggs, milk, entire food group
☐ 401– Failure to meet Dietary Guidelines for Americans (>=24 m of age)

LIFE STYLE

***3a. In the 3 months before you were pregnant, how many cigarettes did you smoke on an average day?** ____Cigarettes/day

***3b. How many cigarettes do you smoke on an average day now?** ____Cigarettes/day

***3c. Does anyone living in your household smoke inside the home?** ☐ Yes 904 environmental smoke ☐ No

***3d. In the 3 months before you were pregnant, how many alcoholic drinks did you have in an average week?**

____Drinks/week

***3e. Have you consumed alcohol during this pregnancy?** ☐ Yes 372A Use of Alcohol ☐ No

***3f. How many alcoholic drinks do you have in an average week now?**

____Drinks/week

3g. In the three months before you were pregnant, did you use street drugs? How about now? ☐ 372B Illegal Drug Use

3h. What do you do for physical activity?

Listen, ask, and assess for

- *Physical activities*
- *Walking*
- *Playing with children*
- *Safe parks*
- *Access to fitness centers*
- *Activity frequency*

BREASTFEEDING PREPARATION

4a. What have you heard about breastfeeding? ☐ Interested in Breastfeeding

Listen, ask, and assess for

- *Interest in breastfeeding*
- *Myths*
- *Concerns*
- *Support systems*

4b. Do you have previous breastfeeding experience? ☐ Yes ☐ No

☐ 338 pregnant woman currently breastfeeding ____Length of time in weeks

Reason for Stopping:

4c. If previously breastfed, how did it go?

- *Affirm and praise*

4d. What does your family, friends, or partner say about breastfeeding?

4e. Tell me about the changes you have noticed or concerns you have about your breasts.

Listen, ask, and assess for

- *Flat*
- *Inverted*
- *Pierced*
- *Surgeries*
- *Pain/discharge*
- *Size*

SOCIAL ENVIRONMENT

5a. What else can I help you with?

Listen, ask, and assess for

- *Abuse/neglect in the last 6 months*
- *Limited ability to make appropriate feeding decision or prepare foods*
- *Family planning*

(ask only if a peer counselor program is available in your agency)

We have moms who have breastfed before and can help you with breastfeeding. I will have one call you.

Interested in Breastfeeding Peer Counselor Program ☐ Yes ☐ No

BREASTFEEDING/NOT BREASTFEEDING INTERVIEW

Name/Participant ID:

Assessed by:

Date:

BREASTFEEDING SUPPORT

1/2a. **How is it being a new mom?**
Listen, ask, and assess for
- *Postpartum depression*
- *Struggles*
- *Successes*
- *Caregiver ability*

☐ 361 Clinical Depression
☐ 902 Primary caregiver with limited ability to make feeding decisions

1b. **How is breastfeeding going for you?**
Listen, ask, and assess for
- *Successes*
- *Challenges*
- *Milk supply*
- *Teething/biting*
- *Baby preferring one breast*
- *Baby not interested*
- *Soreness/nipple care*
- *Breast leaking*

☐ 602/ – Breastfeeding Complications
☐ 602a Severe Engorgement
☐ 602b Recurrent plugged ducts
☐ 602c Mastitis
☐ 602d Flat or inverted nipples
☐ 602e Cracked, bleeding or severely sore nipples
☐ 602g Failure of milk to come in by 4 days postpartum
☐ 602h Tandem nursing (BF two siblings who are not twins)

1c. **How long are you planning to breastfeed your infant?**
Listen, ask, and assess for
- *Returning to work or school*
- *Pumping*
- *Storage*
- *Continuation of Breastfeeding*
- *Anticipated or current separation from infant*

1d. **Are you currently employed or attending school >10 hours/week?** ☐ Yes ☐ No

1e. **What type of support do you have for breastfeeding?**
Listen, ask, and assess for
- *Partner/spouse*
- *Other family members*
- *Friends/peers*
- *Work/school environment*

1f. **Do you need any help or assistance from the WIC Program?**
Listen, ask, and assess for
- *Breastfeeding equipment need, current use, type, experience*
- *Lactation specialist*
- *Additional referral*

1g. **We have moms who have breastfed and can help you with breastfeeding. I will have one call you.** *Ask only if a Peer Counselor is available in your agency.*
Interested in the Breastfeeding Peer Counselor Program ☐ Yes ☐ No

HEALTH/MEDICAL

2b. **What concerns do you or your doctor have about your health?**
Listen, ask, and assess for
- *Medical conditions*
- *Family planning*

***2c.** **Any medical conditions, illnesses, or special needs?** ☐ Yes ☐ No

2d. **Are you currently taking any medication?** ☐ Yes ☐ No

***2e.** **Was this your first pregnancy?** ☐ Yes ☐ No

____*Number of previous pregnancies
____*Number of live births
____Number of pregnancies past 20 weeks/5 months
____*Number of babies this pregnancy

2f. **Did you have any complications or special conditions with this pregnancy?**
☐ 303 – Hx of gestational diabetes
☐ 311 – Hx of preterm delivery
☐ 312– Hx of Low Birth Weight infant
☐ 321b– (BF) Multifetal gestation with one or more fetal or neonatal deaths but with one or more infants still living
☐ 321c – (N) Spontaneous abortion, fetal or neonatal loss
☐ 325 – Multifetal gestation

☐ 339 – Hx of congenital birth defects

☐ 304 – Hx of Preeclampsia

2g. **Do you ever have a hard time chewing or eating certain foods?**
Listen, ask, and assess for

- *Oral health care/Referral*
- *Tooth decay*
- *Tooth loss*
- *Impaired ability to eat*
- *Gingivitis*

☐ 381/HY– Dental Problems

NUTRITION PRACTICES

3a. **Tell me what you like to eat and drink.**
Listen, ask, and assess for

- *Drink to thirst*
- *Appetite*
- *Timing of meals*
- *Meals, snack, and drinks*
- *Eating pattern*
- *Frequency*
- *Eating problems*
- *Food preparation*
- *Food likes and dislikes*
- *Folic acid rich foods*
- *Pica*

3b. **What would you like to change about your eating?**

3c. **Is there anything you would like to eat more or less of?**

3d. **Do you take any vitamins, minerals, herbs, or dietary supplements?**

Nutrition Practices:

☐ 427a – consuming supplements with harmful consequences
☐ 427b – consuming diet low in calories
☐ 427c – compulsively ingesting non-food items (pica)
☐ 427d – inadequate vitamin/mineral supplementation
☐ 425e – Ingesting potentially harmful foods (Food Safety)
☐ 353 – Food allergy: wheat, corn, soy, peanuts, eggs, milk,entire food group
☐ 401 – Failure to meet Dietary Guidelines for Americans (>=24 m of age)

3e. **Do you have any problems with food preparation and/or storage?**
Listen, ask, and assess for

- *Refrigeration*
- *Cooking equipment*
- *Family table*
- *Safe water*

LIFE STYLE

***4a.** **In the 3 months before you were pregnant, how many cigarettes did you smoke on an average day?** ____Cigarettes/day

***4b.** **In the last 3 months of your pregnancy, how many cigarettes did you smoke on an average day?** ____Cigarettes/day

***4c.** **How many cigarettes do you smoke on an average day now?** ____Cigarettes/day

***4d.** **Does anyone living in your household smoke inside the home?** ☐ **Yes** ☐ **No**

***4e.** **In the 3 months before you were pregnant, how many alcoholic drinks did you have in an average week?** ____Drinks/week

***4f.** **In the last 3 months of your pregnancy, how many alcoholic drinks did you have in an average week?** ___Drinks/week

4g. **Do you currently drink alcohol?** ☐ Yes ☐ No **If yes, how much and how often?**

___Drinks/week 372 *Routine or current use of ≥ 2 or more drinks/day or binge drinking on one day in the past 30 days*

4g. **In the three months before you were pregnant, did you use street drugs? How about now?** **Yes** ☐ 372 Illegal Drug Use

4h. **What are your plans for returning to your pre-pregnancy shape**
Listen, ask, and assess for

- *Physical activities*
- *Walking*
- *Playing with children*
- *Safe parks*
- *Access to fitness centers*
- *Activity frequency*
- *Food consumption changes*

SOCIAL ENVIRONMENT

5a. **What else can I help you with?**
Listen, ask, and assess for

- *Abuse/neglect in the last 6 months*
- *Limited ability to make appropriate feeding decision or prepare foods*
- *Family planning*

INFANT INTERVIEW – BREASTFEEDING/PARTIAL

Name/Participant ID:
Date:
Date of Birth:
Assessed By:

NUTRITION PRACTICES

1a. **Tell me how it is feeding <baby's name>.**
Listen, ask, and assess for

- *Hunger and satiety cues*
- *Number of wet/dirty diapers*
- *Appetite changes*
- *Vomiting*
- *Breastfeeding or formula*
- *Constipation or Diarrhea*

1b. **What challenges are you having?**
Listen, ask and assess for

- *Frequency*
- *Difficulty latching on/positioning*
- *Weak/ineffective suck*
- *Jaundice*
- *Breastfeeding support*

603 Breastfeeding Complications:

☐ 603a – Jaundice
☐ 603b – Weak or ineffective suck
☐ 603c – Difficulty latching on to mother's breast
☐ 603d – Inadequate stooling for age and/or <6 wet diapers/day

1c. **If bottle feeding, listen, ask, and assess for**

- *Amount of breast milk/formula*
- *Ounces/bottle and bottles/day*
- *Formula brand/type*
- *How is formula mixed*
- *Water source*
- *Contents other than breast milk/formula*
- *Storage/handling*

1d. **Has your baby received anything besides breastmilk?** ☐ Yes ☐ No

Age in weeks: ___

***1e.** **How old was <baby's name> when he/she was first fed something other than breast milk?**

Age in weeks: ___

***1f.** **How old was <baby's name> when he/she was first fed formula?**

Age in weeks: ___

***Breastfeeding Description:**

☐ Exclusively Breastfeeding - Exclusive
☐ Primarily Exclusive/No Food Package - Exclusive
☐ Primarily Exclusive/Complementary Foods – No formula or minimal formula issued
☐ Partially Breastfeeding – Formula Issued – token/novel or partial
☐ No longer Breastfeeding
☐ Never Breastfed

1g. **What else do you feed <baby's name>?**
Listen, ask, and assess for

- *Early introduction of solids*
- *Developmentally appropriate foods*
- *Cup feeding – type, use, contents*

1h. **What led to <baby's name> getting other food/drink?**

1j. **Does your baby take any vitamins or minerals?** ☐ Yes ☐ No

1k. **Does your baby take any herbs or dietary supplements?** ☐ Yes ☐ No

1l. What questions do you have about breastfeeding <baby's name>?

Listen, ask, assess for

- *Teething/biting*
- *Baby preferring one breast*
- *Baby not interested*
- *Breast leaking/nipple care*
- *Fullness and engorgement*
- *Breast pump needs/questions*
- *Plans for returning to work/school*

Nutrition Practices:

☐ 411a– Inappropriate substitute for breast milk or formula
☐ 411b– Improper bottle/cup use
☐ 411c – Complementary foods inappropriate in type or timing
☐ 411d – Disregarding developmental needs
☐ 411e – Feeding potentially harmful foods (Food Safety)
☐ 411f – Inappropriately diluted formula
☐ 411g – Inadequate Breastfeeding (exclusively Breastfed)
☐ 411h – Diet low in calories/nutrients
☐ 411i – Unsafe handling of formula or expressed breast milk
☐ 411j/ – Dietary supplements with potentially harmful consequences
☐ 411k – Inadequate fluoride and/or Vitamin D supplementation (when necessary)

Other Nutrition Risk Factors:

☐ 353 – Food Allergy: Wheat, corn, soy, peanuts, eggs, milk, entire food group
☐ 428 – Complementary Feeding Practices (4 mos to <24 mos)

1m. What other questions or concerns do you have about feeding <baby's name>? Is there anything you would like to change?

Listen, ask, and assess for

- *Dietary progression*
- *Making baby food*
- *When to start solids*
- *Introducing a cup*
- *Weaning breast/bottle*
- *Type of solids*

HEALTH/MEDICAL

2a. What concerns do you have about <baby's name>'s health?

2b. Does <baby's name> have any medical problems diagnosed by a doctor? ☐ Yes ☐ No

2c. Is <baby's name> currently on any medication? ☐ Yes ☐ No

IMMUNIZATIONS

3a. Can we look over <child's name>'s shot record today?

***3b. Have any DTaP shots been given?** ☐ Yes ☐ No ____# DTap*

ORAL HEALTH

4a. What questions do you have regarding caring for <baby's name>'s gums and teeth?

☐ 381 Dental Problems

LIFE STYLE

5a. How active is <baby's name> every day?

Listen, ask, and assess for

- *Strollers*
- *Play pens*
- *Infant seats*
- *Car seats*
- *Crawling*
- *Rolling over*
- *Moving muscles (massage)*
- *Walking*

***5b. Does anyone living in your household smoke inside the home?** ☐ Yes – 904 Environmental Smoke Exposure

INFANT INTERVIEW – FORMULA FEEDING

Name/Participant ID:
Date: **Date of Birth:**
Assessed By:

NUTRITION PRACTICES

1a. **Did you ever breastfeed <baby's name>?** ☐ Yes ☐ No

***1b.** **If so, how old was <baby's name> when he/she completely stopped breastfeeding or being fed breast milk?**

Age in weeks: ___

1c. **What was your main reason for stopping breastfeeding?**

***1d.** **How old was <baby's name> when he/she was first fed something other than breast milk?**

Age in weeks: ___

***1e.** **How old was <baby's name> when he/she was first fed formula?**

Age in weeks: ___

***Breastfeeding Description:**
☐ Exclusively Breastfeeding
☐ Primarily Exclusive/No Food Package – Exclusive Breastfeeding
☐ Primarily Exclusive/Complementary Foods – No formula or minimal formula issued
☐ Partially Breastfeeding – Formula Issued – token/novel or partial
☐ No longer Breastfeeding
☐ Never Breastfed

1f. **Tell me, how it is feeding <baby's name>?**
Listen, ask, and assess for

- *Hunger and satiety cues*
- *Number of wet/dirty diapers*
- *Appetite changes*
- Constipation or diarrhea
- Vomiting

1g. **Describe how you prepare the formula.**

- *Amount of formula*
- *Ounces/bottle and bottles/day*
- *Formula brand/type*
- *How is formula mixed*
- *Water source*
- *Contents other than formula*
- *Storage/handling*

1h. **Besides formula, what else do you feed <baby's name>?**
Listen, ask, and assess for

- *Early introduction of solids or other liquids*
- *Developmentally appropriate foods*
- *Cup feeding – type, use, contents*

1i. **Does your baby take any vitamins or minerals?** ☐ Yes ☐ No

1j. **Does your baby take any herbs or dietary supplements?** ☐ Yes ☐ No

1k. **What other questions or concerns do you have about feeding <baby's name>? Or is there anything you would like to change?**
Listen, ask, and assess for

- *Dietary progression*
- *Making baby food*
- *When to start solids*
- *Introducing a cup*
- *Weaning breast/bottle*
- *Type of solids*

Nutrition Practices:
☐ 411a– Inappropriate substitute for breast milk or formula
☐ 411b– Improper bottle/cup use
☐ 411c – Complementary foods inappropriate in type or timing
☐ 411d – Disregarding developmental needs
☐ 411e – Feeding potentially harmful foods (Food Safety)
☐ 411f – Inappropriately diluted formula
☐ 411g – Inadequate Breastfeeding (exclusively Breastfed)
☐ 411h – Diet low in calories/nutrients
☐ 411i – Unsafe handling of formula or expressed breast milk
☐ 411j – Dietary supplements with potentially harmful consequences
☐ 411k – Inadequate fluoride and/or Vitamin D supplementation (when necessary)

Other Nutrition Risk Factors:
☐ 353 – Food Allergy: Wheat, corn, soy, peanuts, eggs, milk, entire food group
☐ 428 – Complementary Feeding Practices (4 mos to <24 mos)

HEALTH/MEDICAL

2a. **What concerns do you have about <baby's name>'s health?**

2b. **Does <baby's name> have any medical problems diagnosed by a doctor?** ☐ Yes ☐ No

2c. **Is <baby's name> currently on any medication?** ☐ Yes ☐ No

IMMUNIZATIONS

3a. **Can we look over <child's name>'s shot record today?**

***3b.** **DTaP immunization record viewed today** ☐ Yes ☐ No *____# DTap

ORAL HEALTH

4a. **What questions do you have regarding caring for <baby's name>'s gums and teeth?**

☐ 381 Dental Problems

LIFE STYLE

5a. **How active is <baby's name> every day?**

Listen, ask, and assess for

- *Strollers*
- *Play pens*
- *Infant seats*
- *Car seats*
- *Crawling*
- *Rolling over*
- *Moving muscles (massage)*
- *Walking*

***5b.** **Does anyone living in your household smoke inside the home?** ☐ Yes – 904 Environmental Smoke Exposure

CHILD INTERVIEW

Name/Participant ID:

Date:

Date of Birth:

Assessed By:

HEALTH/MEDICAL

1a. **What concerns do you have about <child's name>'s health?**
Listen, ask, and assess

1b. **Does <child's name> have any medical problems diagnosed by a doctor?** ☐ Yes ☐ No

1c. **Is <child's name> currently taking any medication?** ☐ Yes ☐ No
Listen, ask, and assess for

- *Medications that compromise nutritional status*

IMMUNIZATIONS

***2a.** **Have any DTaP shots been given?** ☐ Yes ☐ No ____# DTap*

ORAL HEALTH

3a. **How do you take care of <child's name>'s teeth?**

3b. **Has <child's name> seen a dentist?** ☐ Yes ☐ No ☐ 381 Dental Problems

LIFE STYLE

4a. **What types of activities does <child's name> enjoy?**

***4b.** **___# of hours of TV watching/video playing per day?**

***4c.** **Does anyone living in your household smoke inside the home?** ☐ Yes – 904/Environmental Smoke Exposure

NUTRITION PRACTICES

***5a.** **Breastfeeding Description:** ☐ Never Breastfed ☐ Breastfeeding Child ☐ No longer Breastfeeding

***5b.** **How old was<child's name> when they stopped breastfeeding?** _____Age in weeks

5c. **Why did <child's name> stop breastfeeding?**

5d. **Tell me about <child's name>'s eating and what she/he likes to drink.**
Listen, ask, and assess for

- *Appetite*
- *Eating Pattern*
- *Frequency*
- *Eating problems*
- *Beverages/Containers*
- *Food preparation*
- *Food jags/refusal*
- *Food likes and dislikes*
- *Pica*

5e. **What is mealtime like?**
Listen, ask, and assess for

- *Environment*
- *Tone of mealtime*
- *When, where, with whom*

5f. **Is there anything you would like to see different about <child's name>'s eating?**

5g. **Are there any foods that you would like to see <child's name> eat more or less of?**

5h. **Does <child's name> take any vitamins/minerals?** ☐ Yes ☐ No

5i. **Does <child's name> take any herbs or dietary supplements?** ☐ Yes ☐ No

Nutrition Practices:

☐ 425a - Inappropriate beverages as the primary milk source
☐ 425b - Routine intake of sugar-containing beverages
☐ 425c - Improper bottle/cup/pacifier use
☐ 425d - Disregarding developmental needs
☐ 425e - Feeding potentially harmful foods (Food Safety)
☐ 425f - Diet low in calories/nutrients
☐ 425h - Inadequate fluoride and/or Vitamin D supplementation (when necessary)
☐ 425i - Eating nonfood items (Pica)

Other Risk Factors

☐ 353 – Food allergy: wheat, corn, soy, peanuts, eggs, milk, entire food group
☐ 401 Failure to meet dietary guidelines for Americans
☐ 428 Complementary Feeding Practices <24 months of age

SOCIAL ENVIRONMENT

6a. **What else can I help you with?** *Listen, ask, and assess for:*

- *Abuse/neglect in the last 6 months*
- *Limited ability to make appropriate feeding decisions or prepare foods*

☐902: Primary caregiver with limited ability to make feeding decisions