

## EARLY HEAD START PRENATAL NUTRITIONAL ASSESSMENT

Name: \_\_\_\_\_

Date: \_\_\_\_\_

1. Describe what your typical meals look like or write down what you ate yesterday for the following meals:

Breakfast:

Lunch:

Dinner:

Snack:

2. Do you consider your appetite to be:      Good      Fair      Poor
3. How many times do you eat fast food in a week? \_\_\_\_\_
4. Who is responsible for the grocery shopping in your home?
5. How do you feel about your current weight and your weight gain during pregnancy?
6. What are some physical activities you like to do?
7. Are you taking a prescribed prenatal vitamin?      Yes      No
8. Are you on the WIC program?      Yes      No
9. When was your last dental visit? \_\_\_\_\_
10. When was your last prenatal visit? \_\_\_\_\_
11. What questions do you have about nutrition during your pregnancy?

EARLY HEAD START POST NATAL ASSESSMENT

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Baby's Name: \_\_\_\_\_

DOB: \_\_\_\_\_

1. What was your labor and delivery like?
2. Vaginal C-section?
3. Any complications during delivery?
4. Was anyone with you during your delivery?
5. How are you feeling?
6. Are you breast-feeding bottle-feeding?
7. Any concern with your baby's feeding or appetite?
8. Health Department Nurse follow up appointment: \_\_\_\_\_
9. When is your follow-up appointment with your Doctor/Midwife? \_\_\_\_\_
10. When is your baby's first well baby check?
11. Is your baby receiving WIC? Yes No
12. Are there any questions you have or resources you need?