



**Mid-America Head Start Infant Nutrition Survey**  
(Birth through 11 months)

Child's name \_\_\_\_\_ Child's age \_\_\_\_\_

**1. How would you describe feeding time with your baby?** *(Check all that apply)*

- Easy
- Sometimes difficult
- Always difficult

**2. How does your baby let you know he/she is hungry or has had enough to eat?**

**3. How many times a day does your baby eat?**

**4. How much does your baby eat at each feeding?**

**5. How is your baby usually fed?** *(Check all that apply)*

- You hold the baby
- While baby is in infant/car seat
- Propping up the bottle
- Baby hold his/her own bottle

**6. What type of milk or formula do you feed your baby?** *(Check all that apply)*

- Breast milk
- Iron-fortified infant formula
- Low-iron infant formula
- Goat's milk
- Evaporated milk
- Whole milk
- Reduced-fat (2%) milk
- Low-fat (1%) milk
- Fat-free (skim)

**7. How do you prepare your baby's formula?**

**8. Which of the following liquids do you put in your baby's bottle or sippy cup?**

- Formula
- Milk
- 100% juice
- Fruit drinks (Kool-Aid, Sunny D, Capri Sun, Tampico, and Hi-C)
- Soft drinks
- Coffee or tea
- Water

**9. How much juice does your baby/toddler drink every day?**

- 4 oz.
- 6 oz.
- 8 oz.
- More than 8 oz.

**10. Do you ever add honey, syrup or sugar to your baby's bottle?**

- Yes  No

**11. Do you ever put cereal in your baby's bottle?**

- Yes  No

**12. Does your baby ever take a bottle or sippy cup to bed?**

- Yes  No

**13. Do you wipe your baby's gums after feeding?**

- Yes  No

**14. How much time does your baby spend in a swing, infant seat or walker?**

**15. How much time does your baby spend in a play pen or on a blanket/mat on the floor?**

**16. What information have you received from your pediatrician/physician about feeding your baby?**

**17. Does your baby or toddler eat solid foods? Check all that apply.**

<i>Food</i>	<i>Age food was introduced</i>
<input type="checkbox"/> Infant cereal	_____
<input type="checkbox"/> Vegetables	_____
<input type="checkbox"/> Fruits/juices	_____
<input type="checkbox"/> Eggs	_____
<input type="checkbox"/> Meat	_____
<input type="checkbox"/> Table food	_____
<input type="checkbox"/> Other _____	_____

**18. Do you have a working stove, oven and refrigerator where you live?**

Yes  No

**19. Were there any days last month when your family didn't have enough food to eat or enough money to buy food?**

Yes  No

**20. Does your child receive WIC? Where do you get your vouchers? \_\_\_\_\_**

**21. What concerns or questions do you have about feeding your baby?**

**Parent/Guardian Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Head Start Staff Signature** \_\_\_\_\_ **Date** \_\_\_\_\_