



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
WIC AND NUTRITION SERVICES
WIC CERTIFICATION - WOMEN

| | |
|----------------|---------------|
| AGENCY NUMBER: | TODAY'S DATE: |
|----------------|---------------|

DEMOGRAPHICS

| | | | | | | |
|-------------------------|--------------|---|--|--|--|-------------------------------|
| PARTICIPANT'S LAST NAME | | PARTICIPANT'S FIRST NAME | | INITIAL CONTACT DATE | | <input type="checkbox"/> Cert |
| | | | | Walk-in _____ Phone call _____ Online Interest form _____ | | <input type="checkbox"/> MCA |
| BIRTH DATE | STATE WIC ID | GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female | | <input type="checkbox"/> Non-breastfeeding <input type="checkbox"/> Fully breastfeeding | <input type="checkbox"/> Mostly breastfeeding <input type="checkbox"/> Some breastfeeding | |
| ADDRESS | | | | PHONE NUMBER AND COMMENTS | | |
| E-MAIL | | | | | | |

Ethnicity: Hispanic or Latino: Yes No
 Race: White Black/African American American Indian/Alaskan Asian Native Hawaiian/Pacific Islander
 Homeless: Date Verified: _____ Fixed Nighttime Location: _____

| | |
|--|--|
| <input type="checkbox"/> ID Proof <input type="checkbox"/> Pending Proof: | <input type="checkbox"/> Residency Proof <input type="checkbox"/> Pending Proof: |
| <input type="checkbox"/> Driver license | <input type="checkbox"/> Disaster, homeless or migrant victim scan attestation |
| <input type="checkbox"/> Hospital or other records | <input type="checkbox"/> Employee statement |
| <input type="checkbox"/> Military ID | <input type="checkbox"/> Government correspondence (not WIC) |
| <input type="checkbox"/> Official ID with picture (state passport) | <input type="checkbox"/> Hospital record |
| <input type="checkbox"/> School ID | <input type="checkbox"/> Pay stub with physical address |
| <input type="checkbox"/> Social services letter with identifying information | <input type="checkbox"/> Rent or mortgage receipt |
| <input type="checkbox"/> Voter registration card | <input type="checkbox"/> Social services agency award letter |
| <input type="checkbox"/> WIC staff recognition (recert) | <input type="checkbox"/> Utility or personal bills/Bank or loan statements |
| <input type="checkbox"/> Work ID | <input type="checkbox"/> Voter registration card/Property tax receipt |
| <input type="checkbox"/> Other (See policy 8.1.210 and document in General note in MOWINS) | <input type="checkbox"/> Written statement from church/legal aid society/shelter |

| | | |
|-------------------|---|--|
| MAIDEN LAST NAME: | PHYSICALLY PRESENT: <input type="checkbox"/> Yes <input type="checkbox"/> No | Reason Not Present: <input type="checkbox"/> Disability <input type="checkbox"/> Working parents or caretaker <input type="checkbox"/> Receiving ongoing healthcare <input type="checkbox"/> Infants under 8 weeks of age |
| MAIDEN FIRST NAME | MIGRANT: <input type="checkbox"/> Yes <input type="checkbox"/> No | |

Income Eligibility Determination: Pending proof Not adjunct eligible

Adjunct Eligibility:
 Applicant receives benefits from:
 Supplemental Nutrition Assistance Program (SNAP)
 MO HealthNet
 Temporary Assistance for Needy Families (TANF)
OR
 Applicant is:
 A member of a household eligible for TANF
 A member of a household with a prenatal or infant eligible for MO HealthNet

| | |
|----------------------------|---|
| Household Size: | Payment Frequency and Amount : |
| <input type="checkbox"/> 1 | <input type="checkbox"/> Hourly _____ |
| <input type="checkbox"/> 2 | <input type="checkbox"/> Weekly _____ |
| <input type="checkbox"/> 3 | <input type="checkbox"/> Monthly _____ |
| <input type="checkbox"/> 4 | <input type="checkbox"/> Bi-monthly _____ |
| <input type="checkbox"/> 5 | <input type="checkbox"/> Semi-monthly _____ |
| <input type="checkbox"/> 6 | <input type="checkbox"/> Yearly _____ |
| <input type="checkbox"/> 7 | |

[Note]
 • WIC income eligibility is based on gross monthly income before taxes and household size.

ADDITIONAL INFORMATION #1

How did you hear about the WIC program:

| | | | | |
|---|--|----------------------------------|---|---|
| <input type="checkbox"/> Health care provider | <input type="checkbox"/> Friend or family | <input type="checkbox"/> YouTube | <input type="checkbox"/> Social services agency | <input type="checkbox"/> Online Interest form |
| <input type="checkbox"/> School or child care | <input type="checkbox"/> Facebook or Instagram | <input type="checkbox"/> Radio | <input type="checkbox"/> Local agency advertisement | |

ADDITIONAL INFORMATION #2

| | | | | |
|--|---|-------------------------------------|--|--|
| <input type="checkbox"/> Need Interpreter | Correspondence Preference | | <input type="checkbox"/> English | <input type="checkbox"/> Spanish |
| Household Language 1 | <input type="checkbox"/> Read | <input type="checkbox"/> Spoken | Household Language 2 | <input type="checkbox"/> Read <input type="checkbox"/> Spoken |
| <input type="checkbox"/> Albanian <input type="checkbox"/> Chinese | <input type="checkbox"/> Italian <input type="checkbox"/> Spanish | <input type="checkbox"/> Ukrainian | <input type="checkbox"/> Albanian <input type="checkbox"/> Chinese | <input type="checkbox"/> Italian <input type="checkbox"/> Spanish |
| <input type="checkbox"/> Arabic <input type="checkbox"/> English | <input type="checkbox"/> Korean <input type="checkbox"/> Urdu | <input type="checkbox"/> Vietnamese | <input type="checkbox"/> Arabic <input type="checkbox"/> English | <input type="checkbox"/> Korean <input type="checkbox"/> Ukrainian |
| <input type="checkbox"/> Baillie <input type="checkbox"/> Farsi | <input type="checkbox"/> Romanian <input type="checkbox"/> Vietnamese | <input type="checkbox"/> Other | <input type="checkbox"/> Baillie <input type="checkbox"/> Farsi | <input type="checkbox"/> Romanian <input type="checkbox"/> Urdu |
| <input type="checkbox"/> Bosnian <input type="checkbox"/> French | <input type="checkbox"/> Russian <input type="checkbox"/> Vietnamese | | <input type="checkbox"/> Bosnian <input type="checkbox"/> French | <input type="checkbox"/> Russian <input type="checkbox"/> Vietnamese |
| <input type="checkbox"/> Bulgarian <input type="checkbox"/> German | <input type="checkbox"/> Sign <input type="checkbox"/> Other | | <input type="checkbox"/> Bulgarian <input type="checkbox"/> German | <input type="checkbox"/> Sign <input type="checkbox"/> Other |
| <input type="checkbox"/> Burmese <input type="checkbox"/> Hmong | <input type="checkbox"/> Somali | | <input type="checkbox"/> Burmese <input type="checkbox"/> Hmong | <input type="checkbox"/> Somali |

EBT HOUSEHOLD DEMOGRAPHIC

| | | | |
|--|---|---|---|
| AUTHORIZED REPRESENTATIVE (REP.) - LAST NAME | | AUTHORIZED REPRESENTATIVE (REP.) - FIRST NAME | |
| Marital Status: | Registered to Vote: | Educational Level: | |
| <input type="checkbox"/> Declined | <input type="checkbox"/> Selected to register | <input type="checkbox"/> 7th grade | <input type="checkbox"/> 2 years of college |
| <input type="checkbox"/> Single | <input type="checkbox"/> Declined to register | <input type="checkbox"/> 8th grade | <input type="checkbox"/> 3 years of college |
| <input type="checkbox"/> Married | <input type="checkbox"/> Already registered | <input type="checkbox"/> 9th grade | <input type="checkbox"/> 4 or 5 years of college |
| <input type="checkbox"/> Widow | | <input type="checkbox"/> 10th grade | <input type="checkbox"/> 1 year graduate school |
| <input type="checkbox"/> Divorced | | <input type="checkbox"/> 11th grade | <input type="checkbox"/> 2 or more years of graduate school |
| <input type="checkbox"/> Separated | | <input type="checkbox"/> 12th grade or GED | <input type="checkbox"/> Unknown |
| | | <input type="checkbox"/> 1 year of college | |

| | | | | |
|---------------------------------------|------------------------------------|--|---|--|
| ALTERNATE REP. / PROXY 1 - LAST NAME | <input type="checkbox"/> Alt. Rep. | Relationship <input type="checkbox"/> Self <input type="checkbox"/> Mother/stepmother <input type="checkbox"/> Father/stepfather <input type="checkbox"/> Family member | <input type="checkbox"/> Legal guardian <input type="checkbox"/> Foster parent <input type="checkbox"/> Other | DATE OF BIRTH |
| ALTERNATE REP. / PROXY 1 - FIRST NAME | <input type="checkbox"/> Proxy | | | PRIMARY CARDHOLDER <input type="checkbox"/> Yes <input type="checkbox"/> No |
| ALTERNATE REP. / PROXY 1 - LAST NAME | <input type="checkbox"/> Alt. Rep. | Relationship <input type="checkbox"/> Self <input type="checkbox"/> Mother/stepmother <input type="checkbox"/> Father/stepfather <input type="checkbox"/> Family member | <input type="checkbox"/> Legal guardian <input type="checkbox"/> Foster parent <input type="checkbox"/> Other | DATE OF BIRTH |
| ALTERNATE REP. / PROXY 1 - FIRST NAME | <input type="checkbox"/> Proxy | | | PRIMARY CARDHOLDER <input type="checkbox"/> Yes <input type="checkbox"/> No |
| ALTERNATE REP. / PROXY 2 - LAST NAME | <input type="checkbox"/> Alt. Rep. | Relationship <input type="checkbox"/> Self <input type="checkbox"/> Mother/stepmother <input type="checkbox"/> Father/stepfather <input type="checkbox"/> Family member | <input type="checkbox"/> Legal guardian <input type="checkbox"/> Foster parent <input type="checkbox"/> Other | DATE OF BIRTH |
| ALTERNATE REP. / PROXY 2 - FIRST NAME | <input type="checkbox"/> Proxy | | | PRIMARY CARDHOLDER <input type="checkbox"/> Yes <input type="checkbox"/> No |

HEALTH INFORMATION - POSTPARTUM

Expected Delivery: _____ Weight Gained during Pregnancy: _____ C-Section delivery
LMP Started Date: _____ Weight at Delivery: _____ Diabetes mellitus
Actual Delivery Date: _____ Pre-pregnancy BMI: _____ Hypertension or prehypertension
Hospital Discharge Date: _____ Birth Facility: _____

On WIC during most recent pregnancy **Infant(s) Born from This Pregnancy**
 Required Food Package III Infant on WIC
 Did not receive prenatal care Breastfeeding now
 Infant in foster care

Most Recent Pregnancy History:
 Low birth weight Preterm or early term delivery
 Multi-fetal gestation Fetal or neonatal loss or spontaneous abortion

Cigarette Usage: Per Day - Last 3 Months of Pregnancy: _____ **Alcohol Intake:** Drinks/Week - Last 3 months of pregnancy: _____
Per Day - Current: _____ Household Smoking: Yes No **Drinks/Week - Current:** _____

Smoking Change:
 Decrease smoking amount Started smoking
 Did not stop smoking, still smoking Stopped smoking completely
 Increased smoking Tried to stop or decrease but failed
 Did not smoke Unknown or refused to answer

Any History of:
 Gestational diabetes
 Preeclampsia
 Live birth with 18 months

HEALTH INFORMATION - PREGNANCY

Current Pregnancy Information:
 Expecting multiple births Diabetes mellitus
 Planned C-section Gestational diabetes
 Hypertension or prehypertension
 Has not received prenatal care
 Required Food Package III
 Currently breastfeeding infant
 Currently breastfeeding child over one

Expected Delivery: _____ Date Prenatal Care Began: _____
LMP Date: _____ Date Food Package III Verified: _____
Breastfeeding Amount: _____
Date Breastfeeding Verified: _____
Pre-Pregnancy Weight: _____

Previous Pregnancy Information:
Number of Pregnancies: _____ Number of live births: _____ Number of WIC Pregnancies: _____
Number of Pregnancies 20 or more weeks: _____ Last pregnancy ended: _____ Live birth within 18 months

| Multi Vitamin Consumption | Month Prior to Pregnancy | During Pregnancy |
|---------------------------|--------------------------|------------------|
| Less than once a week | | |
| 1 time per week | | |
| 2 times per week | | |
| 3 times per week | | |
| 4 times per week | | |
| 5 times per week | | |
| 6 times per week | | |
| 7 times (daily) per week | | |
| 8 times per week | | |
| Unknown | | |

Alcohol Intake: Drinks/Week - 3 months prior to pregnancy: _____
Drinks/Week current: _____

Cigarette Usage:
 Per day - 3 months prior to pregnancy _____
 Per day - current _____
 Household smoking

Any Pregnancy History:
 Low birth weight
 Gestational diabetes
 Preterm or early term delivery
 Preeclampsia
 Fetal or neonatal loss or 2 or more spontaneous abortion

Smoking Change:
 Stopped smoking completely Stopped smoking completely
 Decrease smoking amount Tried to stop or decrease, but failed
 Did not stop smoking, still smoking Unknown or refused to answer
 Increased smoking
 Did not smoke
 Started smoking

HEIGHT/WEIGHT/BLOOD

HT/WT
Measurement Date: _____ Age at Measurement: _____
Measurement Source: WIC clinic Outside of WIC clinic
Measurement Position: Standing Recumbent
Height: _____ (inches) _____ (eighths)
Weight: _____ (pounds) _____ (ounces) BMI _____ WT% chart: _____

Possible Incorrect Measurement Reason:
 Greater than (>) scale max
 Hospital certification
 Participant disability
 Possible equipment error
 Uncooperative client

HEIGHT/WEIGHT/BLOOD CONTINUED**Blood**

Measurement Date: _____
 Age at Measurement: _____
 Measurement Source: WIC clinic Outside of WIC clinic
 Hgb (gm/dl): _____ Hct (%): _____
 Lead (µg/dl): _____
 Delayed Blood Work:

Reason(s) Blood Work was not Corrected:

- Skip until 15 to 18 months (child only)
- CPA determined skip - WNL (child only)
- Religious beliefs
- Medical condition
- Participant refused
- Equipment malfunction
- Breastfeeding > 6 months (breastfeeding women only)

IMMUNIZATION

Immunization Status: Up to date Not up to date: _____

FOOD PRESCRIPTION

Food Prescription for Certification:

- Food Package V Food Package VI Food Package VII Food Package III
- Tailored Food Package _____

Cycle: 1
 2
 3

RISK FACTORS**Prenatal**

- | | |
|---|--|
| <input type="checkbox"/> 101 Underweight (Women) | <input type="checkbox"/> 352a Infectious Diseases - Acute |
| <input type="checkbox"/> 111 Overweight (Women) | <input type="checkbox"/> 352b Infectious Diseases - Chronic |
| <input type="checkbox"/> 131 Low Maternal Weight Gain (prenatal with one fetus) | <input type="checkbox"/> 353 Food Allergies |
| <input type="checkbox"/> 133 High Maternal Weight Gain (singleton pregnancies) | <input type="checkbox"/> 354 Celiac Disease |
| <input type="checkbox"/> 201 Low Hematocrit/Low Hemoglobin | <input type="checkbox"/> 355 Lactose Intolerance |
| <input type="checkbox"/> 211 Elevated Blood Lead Levels | <input type="checkbox"/> 356 Hypoglycemia |
| <input type="checkbox"/> 301 Hyperemesis Gravidarum | <input type="checkbox"/> 357 Drug Nutrient Interactions |
| <input type="checkbox"/> 302 Gestational Diabetes (current pregnancy only) | <input type="checkbox"/> 358 Eating Disorders (anorexia nervosa and bulimia) |
| <input type="checkbox"/> 303 History of Gestational Diabetes (any history of) | <input type="checkbox"/> 359 Recent Major Surgery, Physical Trauma, Burns |
| <input type="checkbox"/> 304 History of Preeclampsia (any history of) | <input type="checkbox"/> 360 Other Medical Conditions |
| <input type="checkbox"/> 311 History of Preterm or Early Term Delivery (any history of) | <input type="checkbox"/> 361 Depression |
| <input type="checkbox"/> 312 History of Low Birth Weight (any history of) | <input type="checkbox"/> 362 Developmental, Sensory or Motor Disabilities Interfering with the Ability to Eat |
| <input type="checkbox"/> 321 History of Spontaneous Abortion, Fetal Death or Neonatal Loss (any history of) | <input type="checkbox"/> 371 Maternal Smoking |
| <input type="checkbox"/> 331 Pregnancy at a Young Age (current pregnancy only) | <input type="checkbox"/> 372 Alcohol and Substance Use |
| <input type="checkbox"/> 332 Short Interpregnancy Interval (current pregnancy only) | <input type="checkbox"/> 381 Oral Health Conditions |
| <input type="checkbox"/> 333 High Parity and Young Age (current pregnancy only) | <input type="checkbox"/> 382 Fetal Alcohol Spectrum Disorders |
| <input type="checkbox"/> 334 Lack of/or Inadequate Prenatal Care | <input type="checkbox"/> 401 Failure to Meet Dietary Guidelines for Americans |
| <input type="checkbox"/> 335 Multi-fetal Gestation | <input type="checkbox"/> 427 Inappropriate Nutrition Practices for Women |
| <input type="checkbox"/> 336 Fetal Growth Restriction | <input type="checkbox"/> 502 Transfer of Certification |
| <input type="checkbox"/> 337 History of Birth of a Large for Gestational Age Infant | <input type="checkbox"/> 503 Presumptive Eligibility for Pregnant Women (Up to 60 days certification) |
| <input type="checkbox"/> 338 Pregnant Woman Currently Breastfeeding | <input type="checkbox"/> 601 Breastfeeding Mother of an Infant at Nutritional Risk |
| <input type="checkbox"/> 339 History of Birth with Nutrition Related Congenital or Birth Defect | <input type="checkbox"/> 602 Breastfeeding Complications or Potential Complications (Women) (pregnant woman currently breastfeeding an infant/child) |
| <input type="checkbox"/> 341 Nutrient Deficiency or Disease | <input type="checkbox"/> 801 Homelessness |
| <input type="checkbox"/> 342 Gastrointestinal Disorders | <input type="checkbox"/> 802 Migrancy |
| <input type="checkbox"/> 343 Diabetes Mellitus | <input type="checkbox"/> 901 Recipient of Abuse |
| <input type="checkbox"/> 344 Thyroid Disorders | <input type="checkbox"/> 902 Women or Infant/Child of Primary Caregiver with Limited Ability to Make Feeding Decisions and/or Prepare Food |
| <input type="checkbox"/> 345 Hypertension and Prehypertension | <input type="checkbox"/> 903 Foster Care |
| <input type="checkbox"/> 346 Renal Disease | <input type="checkbox"/> 904 Environmental Tobacco Smoke [ETS] Exposure |
| <input type="checkbox"/> 347 Cancer | |
| <input type="checkbox"/> 348 Central Nervous System Disorders | |
| <input type="checkbox"/> 349 Genetic and Congenital Disorders | |
| <input type="checkbox"/> 351 Inborn Errors of Metabolism | |

Breastfeeding

- | | |
|---|--|
| <input type="checkbox"/> 101 Underweight | <input type="checkbox"/> 342 Gastrointestinal Disorders |
| <input type="checkbox"/> 111 Overweight | <input type="checkbox"/> 343 Diabetes Mellitus |
| <input type="checkbox"/> 133 High Maternal Weight Gain (singleton pregnancies) | <input type="checkbox"/> 344 Thyroid Disorders |
| <input type="checkbox"/> 201 Low Hematocrit/Low Hemoglobin | <input type="checkbox"/> 345 Hypertension and Prehypertension |
| <input type="checkbox"/> 211 Elevated Blood Lead Levels | <input type="checkbox"/> 346 Renal Disease |
| <input type="checkbox"/> 303 History of Gestational Diabetes (any history of) | <input type="checkbox"/> 347 Cancer |
| <input type="checkbox"/> 304 History of Preeclampsia (any history of) | <input type="checkbox"/> 348 Central Nervous System Disorders |
| <input type="checkbox"/> 311 History of Preterm or Early Term Delivery (any history of) | <input type="checkbox"/> 349 Genetic and Congenital Disorders |
| <input type="checkbox"/> 312 History of Low Birth Weight (any history of) | <input type="checkbox"/> 351 Inborn Errors of Metabolism |
| <input type="checkbox"/> 321 History of Spontaneous Abortion, Fetal Death or Neonatal Loss (any history of) | <input type="checkbox"/> 352a Infectious Diseases - Acute |
| <input type="checkbox"/> 331 Pregnancy at a Young Age (current pregnancy only) | <input type="checkbox"/> 352b Infectious Diseases - Chronic |
| <input type="checkbox"/> 332 Short Interpregnancy Interval (current pregnancy only) | <input type="checkbox"/> 353 Food Allergies |
| <input type="checkbox"/> 333 High Parity and Young Age (current pregnancy only) | <input type="checkbox"/> 354 Celiac Disease |
| <input type="checkbox"/> 335 Multi-fetal Gestation | <input type="checkbox"/> 355 Lactose Intolerance |
| <input type="checkbox"/> 337 History of Birth of a Large for Gestational Age Infant | <input type="checkbox"/> 356 Hypoglycemia |
| <input type="checkbox"/> 339 History of Birth with Nutrition Related Congenital or Birth Defect | <input type="checkbox"/> 357 Drug Nutrient Interactions |
| <input type="checkbox"/> 341 Nutrient Deficiency or Disease | <input type="checkbox"/> 358 Eating Disorders (anorexia nervosa and bulimia) |
| | <input type="checkbox"/> 359 Recent Major Surgery, Physical Trauma, Burns |
| | <input type="checkbox"/> 360 Other Medical Conditions |

RISK FACTORS CONTINUED**Breastfeeding**

- | | |
|---|--|
| <input type="checkbox"/> 361 Depression | <input type="checkbox"/> 601 Breastfeeding Mother of an Infant at Nutritional Risk |
| <input type="checkbox"/> 362 Developmental, Sensory or Motor Disabilities Interfering with the Ability to Eat | <input type="checkbox"/> 602 Breastfeeding Complications or Potential Complications (Women) |
| <input type="checkbox"/> 363 Pre-Diabetes | <input type="checkbox"/> 801 Homelessness |
| <input type="checkbox"/> 371 Maternal Smoking | <input type="checkbox"/> 802 Migrancy |
| <input type="checkbox"/> 372 Alcohol and Substance Use | <input type="checkbox"/> 901 Recipient of Abuse |
| <input type="checkbox"/> 381 Oral Health Conditions | <input type="checkbox"/> 902 Women or Infant/Child of Primary Caregiver with Limited Ability to Make Feeding Decisions and/or Prepare Food |
| <input type="checkbox"/> 382 Fetal Alcohol Spectrum Disorders | <input type="checkbox"/> 903 Foster Care |
| <input type="checkbox"/> 401 Failure to Meet Dietary Guidelines for Americans | <input type="checkbox"/> 904 Environmental Tobacco Smoke [ETS] Exposure |
| <input type="checkbox"/> 427 Inappropriate Nutrition Practices for Women | |
| <input type="checkbox"/> 501 Possibility of Regression | |
| <input type="checkbox"/> 502 Transfer of Certification | |

Postpartum

- | | |
|---|--|
| <input type="checkbox"/> 101 Underweight (Women) | <input type="checkbox"/> 353 Food Allergies |
| <input type="checkbox"/> 111 Overweight (Women) | <input type="checkbox"/> 354 Celiac Disease |
| <input type="checkbox"/> 133 High Maternal Weight Gain (singleton pregnancies) | <input type="checkbox"/> 355 Lactose Intolerance |
| <input type="checkbox"/> 201 Low Hematocrit/Low Hemoglobin | <input type="checkbox"/> 356 Hypoglycemia |
| <input type="checkbox"/> 211 Elevated Blood Lead Levels | <input type="checkbox"/> 357 Drug Nutrient Interactions |
| <input type="checkbox"/> 303 History of Gestational Diabetes (any history of) | <input type="checkbox"/> 358 Eating Disorders (anorexia nervosa and bulimia) |
| <input type="checkbox"/> 304 History of Preeclampsia (any history of) | <input type="checkbox"/> 359 Recent Major Surgery, Physical Trauma, Burns |
| <input type="checkbox"/> 311 History of Preterm or Early Term Delivery (any history of) | <input type="checkbox"/> 360 Other Medical Conditions |
| <input type="checkbox"/> 312 History of Low Birth Weight (any history of) | <input type="checkbox"/> 361 Depression |
| <input type="checkbox"/> 321 History of Spontaneous Abortion, Fetal Death or Neonatal Loss (any history of) | <input type="checkbox"/> 362 Developmental, Sensory or Motor Disabilities Interfering with the Ability to Eat |
| <input type="checkbox"/> 331 Pregnancy at a Young Age (current pregnancy only) | <input type="checkbox"/> 363 Pre-Diabetes |
| <input type="checkbox"/> 332 Short Interpregnancy Interval (current pregnancy only) | <input type="checkbox"/> 371 Maternal Smoking |
| <input type="checkbox"/> 333 High Parity and Young Age (current pregnancy only) | <input type="checkbox"/> 372 Alcohol and Substance Use |
| <input type="checkbox"/> 335 Multi-fetal Gestation | <input type="checkbox"/> 381 Oral Health Conditions |
| <input type="checkbox"/> 337 History of Birth of a Large for Gestational Age Infant | <input type="checkbox"/> 382 Fetal Alcohol Spectrum Disorders |
| <input type="checkbox"/> 339 History of Birth with Nutrition Related Congenital or Birth Defect | <input type="checkbox"/> 401 Failure to Meet Dietary Guidelines for Americans |
| <input type="checkbox"/> 341 Nutrient Deficiency or Disease | <input type="checkbox"/> 427 Inappropriate Nutrition Practices for Women |
| <input type="checkbox"/> 342 Gastrointestinal Disorders | <input type="checkbox"/> 501 Possibility of Regression |
| <input type="checkbox"/> 343 Diabetes Mellitus | <input type="checkbox"/> 502 Transfer of Certification |
| <input type="checkbox"/> 344 Thyroid Disorders | <input type="checkbox"/> 801 Homelessness |
| <input type="checkbox"/> 345 Hypertension and Prehypertension | <input type="checkbox"/> 802 Migrancy |
| <input type="checkbox"/> 346 Renal Disease | <input type="checkbox"/> 901 Recipient of Abuse |
| <input type="checkbox"/> 347 Cancer | <input type="checkbox"/> 902 Women or Infant/Child of Primary Caregiver with Limited Ability to Make Feeding Decisions and/or Prepare Food |
| <input type="checkbox"/> 348 Central Nervous System Disorders | <input type="checkbox"/> 903 Foster Care |
| <input type="checkbox"/> 349 Genetic and Congenital Disorders | <input type="checkbox"/> 904 Environmental Tobacco Smoke [ETS] Exposure |
| <input type="checkbox"/> 351 Inborn Errors of Metabolism | |
| <input type="checkbox"/> 352a Infectious Diseases - Acute | |
| <input type="checkbox"/> 352b Infectious Diseases - Chronic | |

NUTRITION ASSESSMENT**NUTRITION EDUCATION****REFERRALS**

List Referrals provided to participants by WIC _____

- | | | |
|---|--|---|
| <input type="checkbox"/> Other Program Enrollment | <input type="checkbox"/> Substance Abuse | <input type="checkbox"/> Lead Screening |
| <input type="checkbox"/> Community Services | <input type="checkbox"/> Federal/State Program | <input type="checkbox"/> Medical/Dental Health Services |

APPOINTMENTS

| | |
|-------|----------------|
| DATE: | WHAT TO BRING: |
| TIME: | |

NOTES