

INFANT WIC WORKSHEET

Contact Date: _____	<input type="checkbox"/> New Client/New Group
Date Service Provided: _____	<input type="checkbox"/> New Client/Existing Group
	<input type="checkbox"/> Existing Client
Wizard? <input type="checkbox"/> Prescreen <input type="checkbox"/> EN <input type="checkbox"/> CC <input type="checkbox"/> NC <input type="checkbox"/> HA <input type="checkbox"/> Other _____	

Demographics

Is the current caregiver the birth mother of this child? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Female	<input type="checkbox"/> Male	
Client Last: _____	First: _____	MI: _____	DOB: _____
Caregiver Last: _____	Caregiver First: _____	MI: _____	
Alternate Last: _____	Alternate First: _____	MI: _____	
PHONE: _____	Msg. Phone: _____	Phone Notes: _____	
Address: _____	City: _____	Zip: _____	
<input type="checkbox"/> Homeless	<input type="checkbox"/> Migrant	Language for Interpreter: _____	

Race/Ethnicity

Do you consider your infant Hispanic or Latino? <input type="checkbox"/> Yes <input type="checkbox"/> No	
How do you describe your infant's race? Choose all that apply.	
<input type="checkbox"/> American Indian or Alaska Native	Tribe: _____
<input type="checkbox"/> Asian	
<input type="checkbox"/> Black or African American	
<input type="checkbox"/> Native Hawaiian or other Pacific Islander	
<input type="checkbox"/> White	

Income

Number in Household: _____	<input type="checkbox"/> Medicaid	<input type="checkbox"/> TANF	<input type="checkbox"/> Basic Food Program	<input type="checkbox"/> FDPIR	
Source: _____	Proof: _____	Income Amount: _____	<input type="checkbox"/> Weekly	<input type="checkbox"/> Monthly	<input type="checkbox"/> Yearly
Proof ID: _____	Proof Residency: _____				

Custom Tab

Feeding Method:

Fully BF Partially BF

Birth Length: _____

Birth Weight: _____

Some BF Fully Formula

Gestational Age: _____

Total Preg Wt. Gain: _____

Mom on WIC This Preg? WA No Other State Unknown

Breastfed: Currently Stopped: _____ (date) Never

Date Formula/Milk Intro: _____ Date Solids Intro: _____ Medical Provider: _____

Measures

Date: _____ Length: _____ - _____/8 Weight: _____ lb. _____ oz. Head Circ: _____ - _____/8

Date Taken: _____ Hgb/Hct: _____ Notes: _____

Assessment

Risk Factors: _____ Risk Factor Notes: _____
Or attach Assessment Questions

PDHR High Risk

Eligibility Begins: _____

Nutrition Education

Topics	Handouts

Referrals

Streamlined Basic Contact

WIC Signature Form

Rights & Responsibilities

ID Check

Check Education

Appointment folder

Voter Registration: _____

Notes:

Staff: _____ Co-sign: _____

Once information is entered into the computer, please shred this document to protect client information.



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