PEACH Survey
Nutrition Screener

Child's Name: ___________________________________ DOB: _________________
Unique Number: __________________ Completed By: _____________________ Date Completed: ____________

Please circle YES or No for each question as it applies to your child. If any YES is circled, add point value in the parentheses () next to YES. If there is a score of 4 or more, refer to Registered Dietitian.

Question	YES	NO
Does your child have a health problem? If yes, what is it?	YES (1)	NO
Does your child take medicine for a health problem? If yes, what?	YES (1)	NO
Is your child on a special diet? If yes, what type?	YES (2)	NO
Is your child small for age? ___Too thin? ___ Too heavy? ___ (If you check any of the above, circle YES)	YES (3)	NO
Circle YES if your child has problems with these on a regular basis: Loose stools___ Hard stools___ Vomiting___ Spitting up___	YES (3)	NO
Does your child have any feeding problems?	YES (3)	NO
Circle YES if your child has problems with: Sucking __ Swallowing___ Chewing__ Gagging___ Holding food/liquid in cheeks___	YES (3)	NO
Does your child use a feed tube or other feeding method? If yes, explain:	YES (4)	NO
Is your child's appetite a problem? If yes, describe:	YES (1)	NO
Does your child refuse to eat, throw food, or do other things that upset you at mealtime? If yes, what?	YES (2)	NO
Circle YES if your child does not eat any of these foods: Milk __ Meats/Beans___ Vegetables___ Fruit___	YES (1)	NO
Does your child have food allergies? If yes, to what foods?	YES (1)	NO
Does your child eat clay, paint chips, dirt, or other things that are not food? If yes, what?	YES (2)	NO
For infants under 12 months who are **breastfed**: Does your child have: Trouble latching on___ Breastfeed less than 4x in 24hr__ Have less than 6-8 wet diapers/day____ Have less than 2-3 dirty diapers/day__	YES (2)	NO
For infants under 12 months who are **bottle fed**: Does your child drink less than 24 oz of formula per day?	YES (1)	NO
For children 12 months- 18 months of age: Is your child not using an open cup? ____ Is your child not finger-feeding? ___	YES (1)	NO
For children over 18 months: Does your child still take most liquids from a bottle? Is your child not using a spoon or fork?	 YES (2) YES (2)	 NO NO
Total YES points=		
Additional Notes:		