



Healthy Families Healthy Futures

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POST-NATAL NUTRITION SCREEN

Client Name: _____

Family #: _____

Date: _____

	YES	NOTES
1. I usually eat less than 4 servings of grain products per day		
2. I usually eat less than 4 servings of fruits and vegetables per day		
3. I usually eat less than 2 servings of milk products per day		
4. I usually eat less than 2 servings of meat or alternatives per day		
5. I eat more than 2 – 3 servings a day of candy, chips, donuts or other snack foods		
6. I drink more than 3 glasses a day of pop or Kool-Aid		
7. I eat fewer than 2 meals per day		
8. I use vitamin, mineral or herbal supplements (please specify)		
9. I weigh at least 10 lbs less or more than I did <u>before</u> I became pregnant		

	YES	NOTES
10. I have an illness or condition that makes me change the kind and/or amount of food I eat. <i>Check all that apply:</i>		
a) Diabetes		
b) Crohn's Disease / Ulcerative Colitis		
c) Cystic Fibrosis		
d) Celiac Disease		
e) Cancer		
f) Liver / Kidney Disease		
g) Anorexia nervosa / Bulimia nervosa		
h) Food allergy (please specify)		
i) Other (please specify)		
10. I do not always have enough money to buy the food I need		
11. I do not know how to cook or do not have a stove or refrigerator		
12. I sometimes skip meals or avoid eating when hungry to control my weight		