



Breastfeeding/Post Partum Women Application

Last Name	First Name	Middle Initial	Birth Date 331,332,333	Today's Date
Social Security Number _____		Is this person Hispanic or Latino? <input type="checkbox"/> No <input type="checkbox"/> Yes		
Select at least one of the following:				
<input type="checkbox"/> American Indian/Alaska Native		<input type="checkbox"/> Asian		<input type="checkbox"/> White
<input type="checkbox"/> Black/African American		<input type="checkbox"/> Native Hawaiian/Pacific Islander		

WIC helps families with healthy food and nutrition choices.

How is **feeding your baby** going? Please, tell us if you have any concerns.

1. Please, tell us if you see a doctor, dietitian or health care provider for medical or emotional reason(s), **ex:** hypertension, pre-hypertension, pre-diabetes, diabetes, anemia or **gastrointestinal disorders**.
201, 302-304, 341-349, 351- 363
Describe: _____
2. **If you were in the hospital in the last 3 months, please, tell us why.** 359

3. **Have you been screened or referred for lead poisoning?**
No Yes 211
4. Write the date of your last dental check-up _____ 381
5. Tell us if you have any problems eating any type of food for any reason such as dental problems, food intolerances, food allergies or others? 353-355, 381
Describe: _____
6. Does anyone smoke cigarettes, cigars, or pipes anywhere inside your home? No Yes 904
7. Does your family stay in a shelter, a temporary home, or in a place not usually used for sleeping?
No Yes 801
8. Do you have a refrigerator, a stove that works and storage free from pests and harmful chemicals?
No Yes 801
9. Did a family member have a seasonal farming job with a temporary home in the last 24 months?
No Yes 802
10. Are you in a relationship with anyone who pushes, hits or threatens you in any way? No Yes 901
11. What problems, if any, do you have caring for yourself or your baby/children? 902
Describe: _____
12. Circle the type of milk you would like on your WIC checks or in your food box:
Fresh Fluid (UHT) Evaporated
Soy Lactose Reduced 355 Dry
13. What concerns, if any, do you have about having enough food to feed your family?
Comment: _____
14. **How are you feeding your baby?**
Breastmilk Breastmilk + Formula Formula Only
If Breastfeeding
How long do you plan to breastfeed? _____ 601
• I breastfeed _____ times in 24 hours 601,602
• Each feeding lasts _____ minutes 602
On a scale of 0 to 10, how confident are you about breastfeeding your baby? (Circle a number)
Not Confident 0 1 2 3 4 5 6 7 8 9 10 Very Confident
If Formula
Did you ever breastfeed? No Yes
If yes, I breastfed _____ days or _____ weeks.
I introduced formula at _____ weeks.

To Be Completed by Health Care Provider (HCP)

Medical date _____ Ht _____ Pre-Pregnancy Wt _____ (101, 111) Current Wt _____ (133) Hgb /Hct _____ (201)
Name of HCP verifying applicant lives in Alaska _____ **ID Verified by:** Visual Recognition ___/Other _____ WIC
Name of CPA reviewing WIC application _____ Certification Date _____



15. On a scale of 0 to 10, how well do think you are eating?
 (Circle a number)
 Not Well 0 1 2 3 4 5 6 7 8 9 10 Very Well

16. I usually eat ___meals /day and ___snacks/day.

17. I eat fruits/vegetables: 1 cup/day or less
 2 cups/day
 3 cups/day or more

18. **Circle if you crave or eat:**
 Ashes Baking Soda Dust
 Carpet Fibers Chalk Cigarettes Soil
 Clay Starch (laundry or corn starch)
 Paint Chips Burnt Matches
 Large quantities of ice and/or freezer frost 427.03

19. List any medication, vitamin, pre-natal vitamins, mineral or herbal supplement you are taking. 357, 427.01

 If not daily, how often? _____ 427.04

20. Have you fasted, binged or vomited to control your weight or followed a specific diet?
 No Yes 358/427.02
 Describe _____

21. **Do** you smoke cigarettes, pipes or cigars?
 No Yes 371
 If yes, how much a day _____

22. Do you use smokeless, chewing tobacco or iqmik?
 No Yes
 How many times per day? _____

23. **Do** you drink wine, beer or other alcoholic beverages?
 No Yes 372
 If yes, how many drinks a day? _____
 If yes, how many drinks a week? _____

24. **Check any drugs you are using.** 372
 Marijuana Methadone Cocaine

Breastfeeding/Post Partum Women Application

Crank Crack Methamphetamine Speed
 Heroin Other None Stopped Using
 If stopped using, when was the last time you used?

25. **How far apart were your last two pregnancies?**
 _____ 332

26. How many babies did you have during your last pregnancy? _____ 335

27. How many times have you been pregnant? (do not count this pregnancy) _____ times

28. How old are your children? _____ 333

29. **Check if you had any of the problems during your recent pregnancy:**
 Baby born 3 or more weeks early 311
 Baby, less than 5 pounds 9 oz. at birth 312
 Miscarried – how many _____ 321
 Baby, more than 9 pounds at birth 337
 Stillbirth – how many _____ 321
 Genetic or birth defects 339
 Had more than one baby- how many _____ 335
 Baby died before 1 month old 321
 C-Section 359
 History of Gestational Diabetes 303
 History of Preeclampsia 304

30. How often do you feel down, depressed or hopeless? 361
 Never Rarely Sometimes
 Often Always

31. What does your family do for fun?

32. **How can WIC help your family today?**

