

Patient's Name: _____ Date of Birth: _____

Race/Ethnicity: Asian/Pacific Islander Black Caucasian Hispanic Native American

How often outside of gym class are you actively playing, exercising, or in sports, that your heart beats fast and you breath hard for 30 minutes or more at a time? (check the one that applies)

Everyday 5-6 days/week 3-4 days/week 1-2 days/week Less than 2 days/week

How many minutes a day do you spend being physically active? _____

How many hours per day do you:

- Play Outside? Less than 1 hour 1-2 hours 3-4 hours 5 hours or more
- Watch TV? Less than 1 hour 1-2 hours 3-4 hours 5 hours or more
- Use the Computer? Less than 1 hour 1-2 hours 3-4 hours 5 hours or more
- Play Video Games? Less than 1 hour 1-2 hours 3-4 hours 5 hours or more
- Cell phone/Music/Tablet? Less than 1 hour 1-2 hours 3-4 hours 5 hours or more

How many times a week do you eat breakfast? _____

How many times a week do you eat dinner at the table together with your family? _____

Food Group	Every Day	Several Times	Once a	Once a	Less than	Never
		Weekly	Week	Month	Once a Month	
Vegetables	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fruits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fried Foods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fast Food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
100% Juice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Juice/Flavored Drinks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sports Drinks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Regular Soda	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Milk	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

please indicate type ____%

Problem Eating Areas (Please check all that apply)

- I usually skip meals
- I eat too large of portions
- I eat at the wrong time of day
- I love sweets and can't stay away from them
- I eat the wrong kinds of foods
- I drink several high calorie beverages daily (whole milk, sodas, juices, sports drinks)
- I eat a lot of fried foods
- I eat when I am bored
- I eat when I am sad/depressed
- I usually eat in front of the TV or computer at least once a day
- I usually eat two or more helpings of food
- We usually use food as a reward at home
- Sometimes I hide when I am eating
- I am never sure when I am full
- I snack too much
- I eat too fast
- I eat when I am happy
- I eat when I am stressed
- I eat when I am angry
- I usually eat at night (after 10pm)

Based on your answers, is there ONE thing you would be interested in changing now? (check one)

- Eat more fruits & vegetables
- Take the TV out of the bedroom
- Increase physical activity
- Switch to skim or low fat milk
- Spend less time watching TV/movies and playing video/computer games
- Eat less fast food/takeout
- Limit portion sizes at meals and snacks
- Drink less soda, juice or punch
- Replace sweet drinks including 100% juice with water