Nutrition and Activity Screening

Patient Name: _____ DOB_____ Date: _____

Dear Parent: Please answer these questions about your child's diet and activity.
Thank you for your time.

What your child eats:

- Breakfast:_____
- Lunch: _____
- Supper: _____

Snack Foods:

- How many snacks does your child eat on typical day? _____
- What are the usual snacks your child eats? _____

Vitamins:

- Does you child take a daily multivitamin or supplement? Yes No

Drinks:

- How many glasses of the following does your child drink on a typical day?

Milk: _____ Kind of milk? _____ Juice (orange, apple, grape, etc): _____

Water: _____ Fruit Drinks (Hi-C, Lemonade):_____ Kool-Aid: _____ Soda: _____

Sweet Tea: _____ Other: _____ Please List: _____

Restaurants:

- How many times in the past 7 days did your child eat or have take-out food from a restaurant? _____
- What did they eat? _____

Fruits and Vegetables:

- How many servings of fruit does your child usually eat on a typical day? _____
- List some of the fruits: _____
- How many servings of vegetables does your child usually eat on a typical day? _____
- List some of the vegetables: _____

Activity:

- How many hours of active play does your child have on a typical weekday? _____
- How many hours of active play do your child have on a typical weekend day? _____

Television:

- How many hours of TV/Computer/Video Games does your child watch on a typical weekday? _____
- How many hours of TV/Computer/Video Games does your child watch on a typical weekend? _____
- Does your child have a TV in his/her bedroom? Yes No