



You may want to change logo to your practice name in this space

Healthy Habits Questionnaire Ages 2-9 (parent/caregiver)

DEMOGRAPHICS

Last Name

First Name

DOB

Gender

M

F

Parent/caregiver name: _____ Preferred Phone _____ Home Cell Work

HEALTHY BEHAVIORS ASSESSMENT**

How many servings of fruits or vegetables does your child eat a day? _____

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

How many times a week does your child eat breakfast? _____

How many times a week does your child eat takeout or fast food? _____

How many hours a day does your child watch TV/movies or sit and play video/computer games? _____

Does your child have a TV in the room where he/she sleeps? Yes No

Does your child have a computer in the room where he/she sleeps? Yes No

How many hours of sleep does your child get per night? _____

How much time a day does your child spend in active play (faster breathing/heart rate or sweating)? _____

How many 8-ounce servings of the following does your child drink a day? (A 12-oz serving is the size of a can of soda or pop)

100% juice _____ Fruit drinks or sports drinks _____ Soda or punch _____

Water _____ Whole milk _____ Nonfat or reduced fat milk _____

Are you concerned about any of your child's nutrition or activity habits? _____

Have you recently made any changes to your child's nutrition or activity habits? _____

Have you thought about making any changes to your child's nutrition or activity habits? _____

Please rate the level of stress in your family (select a number)

0 1 2 3 4 5 6 7 8 9 10

Little or no stress

A great deal of stress

NOTES

This space can be used for families or adolescents to tell you any other information or for the clinician to elaborate on any responses

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DEMOGRAPHICS

Last Name

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DOB

Gender M F

Parent/caregiver name: _____ Preferred Phone _____ Home Cell Work

HEALTHY BEHAVIORS ASSESSMENT**

Does your child eat at least five or more servings of fruits and vegetables daily? Yes No

Does your family eat meals together at home 5-6 times a week? Yes No

Does your child eat breakfast every day? Yes No

Does your child eat fast food or takeout more than 2 times a week? Yes No

Does your child watch TV, play video games, or spend time on a computer for more than two hours per day? Yes No

Does your child have a TV in the room where he/she sleeps? Yes No

Does your child have a computer in the room where he/she sleeps? Yes No

Does your child get at least 7-8 hours of sleep every night? Yes No

Does your child participate in active play (faster breathing/heart rate or sweating) for a total of one hour a day? Yes No

Does your child drink more than one 8oz sugar sweetened beverage (soda, juice, sports drink) each day? Yes No

Based on your answers, is there one thing you would like to change? Yes No

This is the quick version of the Healthy Behaviors Assessment. Use this version when you would like to get a quick idea of the nutrition and activity habits of young child.

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DOB

Gender M F

Parent/caregiver name: _____ Preferred Phone _____ Home Cell Work

HEALTHY BEHAVIORS ASSESSMENT**

How many servings of fruits or vegetables does your child eat a day? _____

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

How many times a week does your child eat breakfast? _____

How many times a week does your child eat takeout or fast food? _____

How many hours a day does your child watch TV/movies or sit and play video/computer games? _____

Does your child have a TV in the room where he/she sleeps? Yes No

Does your child have a computer in the room where he/she sleeps? Yes No

How many hours of sleep does your child get per night? _____

How much time a day does your child spend in active play (faster breathing/heart rate or sweating)? _____

How many 8-ounce servings of the following does your child drink a day? (A 12-oz serving is the size of a can of soda or pop)

100% juice _____ Fruit drinks or sports drinks _____ Soda or punch _____

Water _____ Whole milk _____ Nonfat or reduced fat milk _____

Are you concerned about any of your child's nutrition or activity habits? _____

Have you recently made any changes to your child's nutrition or activity habits? _____

Have you thought about making any changes to your child's nutrition or activity habits? _____

Please rate the level of stress in your family (select a number)

0 1 2 3 4 5 6 7 8 9 10

Little or no stress

A great deal of stress

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Healthy Habits Questionnaire
Ages 2-9 (parent/caregiver)

DEMOGRAPHICS

Last Name

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Gender M F

Parent/caregiver name: _____ **Preferred Phone** _____ Home Cell Work

HEALTHY BEHAVIORS ASSESSMENT**

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Does your family eat meals together at home 5-6 times a week? Yes No

Does your child eat breakfast every day? Yes No

Does your child eat fast food or takeout more than 2 times a week? Yes No

Does your child watch TV, play video games, or spend time on the computer for more than two hours per day? Yes No

Does your child have a TV in the room where he/she sleeps? Yes No

Does your child have a computer in the room where he/she sleeps? Yes No

Does your child get at least 7-8 hours of sleep every night? Yes No

Does your child participate in active play (faster breathing/heart rate or sweating) for a total of one hour a day? Yes No

Does your child drink more than one 8oz sugar sweetened beverage (soda, juice, sports drink) each day? Yes No

Based on your answers, is there one thing you would like to change? Yes No

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Healthy Habits Questionnaire
Ages 10-18

DEMOGRAPHICS

Last Name

First Name

DOB

Gender M F

Parent/caregiver name: _____ Preferred Phone _____ Home Cell Work

HEALTHY BEHAVIORS ASSESSMENT**

How many servings of fruits or vegetables do you eat a day? _____

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

How many times a week do you eat breakfast? _____

How many times a week do you eat takeout or fast food? _____

How many hours a day do you watch TV/movies or sit and play video/computer games? _____

Do you have a TV in your bedroom? Yes No

Do you have a computer in your bedroom? Yes No

How many hours of sleep do you get per night? _____

How much time a day do you spend in active play (faster breathing/heart rate or sweating)? _____

How many 8-ounce servings of the following do you drink a day? (A 12-oz serving is the size of a can of soda or pop)

100% juice _____ Fruit drinks or sports drinks _____ Soda or punch _____

Water _____ Whole milk _____ Nonfat or reduced fat milk _____

Are you concerned about any of your nutrition or activity habits? _____

Have you recently made any changes to your nutrition or activity habits? _____

Have you thought about making any changes to your nutrition or activity habits? _____

Please rate the level of stress in your life (select a number)

0 1 2 3 4 5 6 7 8 9 10

Little or no stress

A great deal of stress

NOTES

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**Healthy Habits Questionnaire
Ages 10-18**

DEMOGRAPHICS

Last Name

First Name

DOB

Gender M F

Parent/caregiver name: _____ Preferred Phone _____ Home Cell Work

HEALTHY BEHAVIORS ASSESSMENT**

Do you eat at least five or more servings of fruits and vegetables daily? Yes No

Does your family eat meals together at home 5-6 times a week? Yes No

Do you eat breakfast every day? Yes No

Do you eat fast food or takeout more than 2 times a week? Yes No

Do you watch TV, play video games, or spend time on the computer for more than two hours per day Yes No

Do you have a TV in your bedroom? Yes No

Do you have a computer your bedroom? Yes No

Do you get at least 7-8 hours of sleep every night? Yes No

Do you participate in active play (faster breathing/heart rate or sweating) for a total of one hour a day? Yes No

Do you drink more than one 8oz sugar sweetened beverage (soda, juice, sports drink) each day? Yes No

Based on your answers, is there one thing you would like to change? Yes No

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