

Healthy Habits Questionnaire

(Ages 2-9)

We are interested in the health and well-being of all our patients. Please take a moment to answer the following questions.

Patient Name:	Age:	Today's Dat	te:	
I. How many servings of fruits or vegetables One serving is most easily identified by the size of th	, , ,			
2. How many times a week does your child e	eat dinner at the table together with the family	?		
3. How many times a week does your child e	eat breakfast?			
4. How many times a week does your child e	eat takeout or fast food?			
5. How many hours a day does your child wa	tch TV/movies or sit and play video/computer	games?		
6. Does your child have a TV in the room where he /she sleeps?			Yes 🗌	No 🗌
7. Does your child have a computer in the room where he /she sleeps?			Yes 🗌	No 🗌
8. How much time a day does your child spe	nd in active play (faster breathing/heart rate or	sweating)?		
9. How many 8-ounce servings of the followi	ng does your child drink a day?			
100% Juice Water	Fruit drinks or sports drinks Whole milk	Soda or punch Nonfat or reduce	ed fat milk	
10. Based on your answers, is there ONI	thing you would like to help your child cl	hange now? Please	check or	ne box.
 Eat more fruits & vegetables. Take the TV out of the bedroom. Play outside more often. 	 Spend less time watching TV/movies and playing video/computer games. Drink less soda, juice, or punch. 	🗌 Drinl	k more wa	od/takeout. ater. or low fat milk.
	Please	give the completed	form to y	our clinician. Thank you.
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