



Healthy Habits Questionnaire

(Ages 10-18)

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 Date: _____

1. How many servings of fruits or vegetables do you eat a day?
(One serving is most easily identified by the size of the palm of your hand.) _____
2. How many times a week do you eat dinner at the table together with your family? _____
3. How many times a week do you eat breakfast? _____
4. How many times a week do you eat takeout or fast food? _____
5. How many hours a day do you watch TV/movies or sit and play video/computer games? _____
6. Do you have a TV in the room where you sleep? Yes No
7. Do you have a computer in the room where you sleep? Yes No
8. How much time a day do you spend in active play
(faster breathing/heart rate or sweating)? _____
9. How many 8-ounce servings of the following do you drink a day?

_____ 100% juice	_____ Fruit or sports drinks	_____ Soda or punch
_____ Water	_____ Whole milk	_____ Nonfat (skim), low-fat (1%), or reduced-fat (2%) milk

10. Based on your answers, is there **ONE** thing you would be interested in changing now? Please check one box.

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|----------------------------------------------------------|-----------------------------------------------------------------------------------------------|----------------------------------------------------------|
| <input type="checkbox"/> Eat more fruits & vegetables. | <input type="checkbox"/> Spend less time watching TV/movies and playing video/computer games. | <input type="checkbox"/> Eat less fast food/takeout. |
| <input type="checkbox"/> Take the TV out of the bedroom. | <input type="checkbox"/> Drink less soda, juice, or punch. | <input type="checkbox"/> Drink more water. |
| <input type="checkbox"/> Play outside more often. | | <input type="checkbox"/> Switch to skim or low fat milk. |

Please give the completed form to your clinician. Thank you.

