

Nutrition and Physical Activity



To be completed by patient and/or parent or guardian.

Patient information

First name: _____

Last name: _____

Date of birth: _____ Gender: _____

Age: _____ Grade in school: _____

Patient email: _____

Family history

Do any family members have any of the following health conditions?

Diabetes: ☐ Patient ☐ Mother ☐ Father
☐ Grandparent ☐ Aunt ☐ Uncle ☐ Other

Heart disease/attack: ☐ Patient ☐ Mother ☐ Father
☐ Grandparent ☐ Aunt ☐ Uncle ☐ Other

High blood pressure: ☐ Patient ☐ Mother ☐ Father
☐ Grandparent ☐ Aunt ☐ Uncle ☐ Other

Obesity: ☐ Patient ☐ Mother ☐ Father
☐ Grandparent ☐ Aunt ☐ Uncle ☐ Other

Parent dieting history (if any): _____

Who grocery shops?: _____

Who does most of the cooking?: _____

Food choices

How many times per day does the patient:

Eat vegetables (exclude french fries)?

☐ 0-1 ☐ 2-3 ☐ 4-5 ☐ 6-7

Eat fruit? ☐ 0-1 ☐ 2-3 ☐ 4-5 ☐ 6-7

Eat fried food? ☐ 0-1 ☐ 2-3 ☐ 4-5 ☐ 6-7

Eats grains? ☐ 0-1 ☐ 2-3 ☐ 4-5 ☐ 6-7

Eats protein? ☐ 0-1 ☐ 2-3 ☐ 4-5 ☐ 6-7

Eat sweets? ☐ 0-1 ☐ 2-3 ☐ 4-5 ☐ 6-7

Eat salty snacks? ☐ 0-1 ☐ 2-3 ☐ 4-5 ☐ 6-7

Drink soda or sweetened fruit drinks?

☐ 0-1 ☐ 2-3 ☐ 4-5 ☐ 6-7

What kind of milk do they drink?

☐ Whole ☐ 2% ☐ 1% ☐ Skim ☐ Soy

How many 8 oz. glasses of milk do they drink per day? _

Meal patterns

How many days per week does the patient:

Eat breakfast? ☐ 0-1 ☐ 2-3 ☐ 4-5 ☐ 6-7

Eat dinner with family? ☐ 0-1 ☐ 2-3 ☐ 4-5 ☐ 6-7

Eat "fast food" meals? ☐ 0-1 ☐ 2-3 ☐ 4-5 ☐ 6-7

Eat meals or snacks in front of TV?

☐ 0-1 ☐ 2-3 ☐ 4-5 ☐ 6-7

Eat meals or snacks in the car?

☐ 0-1 ☐ 2-3 ☐ 4-5 ☐ 6-7

Physical activity

How many days per week does the patient:

Participate in physical education?

☐ 0-1 ☐ 2-3 ☐ 4-5 ☐ 6-7

Participate in physical activity?

☐ 0-1 ☐ 2-3 ☐ 4-5 ☐ 6-7

How many hours per day does the patient:

Watch TV? ☐ 0-1 ☐ 2-3 ☐ 4-5 ☐ 6-7

Use computer or play video games?

☐ 0-1 ☐ 2-3 ☐ 4-5 ☐ 6-7

Does the patient have a TV in their bedroom?

☐ Yes ☐ No

Sleep schedule

When does the patient go to sleep?

During week: _____ Weekends: _____

Questions for parent/guardian

Do you use food as a reward?

☐ Yes ☐ No ☐ Sometimes

Are you concerned about your own weight?

☐ Yes ☐ No

Are you concerned about your child's weight?

☐ Yes ☐ No

Questions for the patient

How concerned am I about my weight?

☐ Very ☐ Sort of ☐ Not very

How much do I want to do something about my weight right now?

☐ Very ☐ Sort of ☐ Not very

How confident am I that I can do something about my weight?

☐ Very ☐ Sort of ☐ Not very

Do I think I can do something about the things that are getting in my way?

☐ Very much ☐ Maybe ☐ Not really

How ready am I to change my eating habits?

☐ Very ☐ Sort of ☐ Not very

How ready am I to become more physically active?

☐ Very ☐ Sort of ☐ Not very

Is my family ready to support me in my efforts?

☐ Very ☐ Sort of ☐ Not very