Healthy Eating and Living Assessment

Parent Questionnaire

Child's Name_____ **Date:** _____

Parent's Name_____

Complete Section 1 and 2 if you are a new patient, if you have never filled out this assessment before, or if there have been any changes in Section 1 or 2.

Section 1: Prenatal and birth history: ***Please circle all that apply to your child*****.**

1. Birth weight _____
2. Diabetes during pregnancy in the mother? **Yes** **No**
3. Mother overweight at the beginning of pregnancy? **Yes** **No**
4. Mother with more than 35 pounds of weight gain during pregnancy? **Yes** **No**
5. Exposure to tobacco smoke during pregnancy? **Yes** **No**
6. LGA (large for gestational age) or SGA (small for gestational age) at birth?

LGA **SGA** **Neither** **Don't know**

Section 2: Family and past medical history: ***Please check all that apply to <u>either your child or to your family</u> (siblings, parents or grandparents).***

	<u>Section 2 A</u>	**<u>Section 2 B</u>**
• Overweight or obese?	☐ **Family member (list)**_____	☐ **My child**
• High blood pressure?	☐ **Family member (list)**_____	☐ **My child**
• High cholesterol?	☐ **Family member (list)**_____	☐ **My child**
• Type 2 diabetes?	☐ **Family member (list)**_____	☐ **My child**
• Heart disease or stroke in anyone 40 years of age or younger?	☐ **Family member (list)**_____	☐ **My child**

Section 3: Lifestyle, Eating and Health Behaviors: ***Please circle all that apply to your child.***

1. Breast or bottle fed as an infant?	**Breast**	**Bottle**	**Both**
2. Introduced to solid foods (baby food, cereal) before 4 months of age?		**Yes**	**No**
3. Eats breakfast daily?		**Yes**	**No**
4. Servings of fruits and vegetables each day?	**Less than 5**		**5 or more**
5. Drinks sweetened beverages (soda, sweet tea, sports drinks, fruit juices, Kool-aid, sweetened coffee)?	**None**	**1-2/week**	**Every day**
6. Eats "second helpings" of food?	**Rarely**	**Often**	**Always**
7. Portion sizes larger than the size of his or her own fist?	**Rarely**	**Often**	**Always**
8. Eats candy, cookies, snack cakes, chips or desserts?	**Rarely**	**Often**	**Every day**
9. Fast food restaurants?	**Almost never**	**Once/week**	**Several/week**
10. Other dining out?	**Almost never**	**Once/week**	**Several/week**
11. Family meals together at the dinner table?	**Rarely**	**Often**	**Always**

12. Total hours per day spent watching TV, or playing the computer, I-pad or video games? (Do not count computer time doing homework.) **Less than 2 hrs** **2-4 hrs** **5 or more hrs**

13. Have a TV in his or her room? **Yes** **No**

14. Eats in front of the TV or while playing computer/video games? **Yes** **No**

15. Time spent <u>each day</u> in physical activity including outside play, exercise or sports? **1 hr or more** **30 minutes** **<30 minutes**

16. What kind of physical activity does your child do? _____

17. What does your child eat for breakfast? _____

_____

18. What does your child eat for lunch? _____

_____

19. Does your child take his or her lunch to school, or buy it? **Take lunch** **Buy lunch**

20. What are common foods that your child eats for dinner? _____

_____

21. Have you or anyone else (family, friends, teacher, doctor, etc.) ever been concerned that your child is overweight? **Yes** **No**

If you answered "yes" to #21, please complete the following questions:

- On a scale of 1 to 10, with 1 being least concerned, and 10 being most concerned, how concerned are you about your child's weight today?

1 2 3 4 5 6 7 8 9 10
Not at all Somewhat Very

- On a scale of 1 to 10, with 1 being least ready, and 10 being most ready, how ready are you to make changes in your child and family's eating and activity behaviors?

1 2 3 4 5 6 7 8 9 10
Not at all Somewhat Very

22. ***Please check below any of the specific lifestyle changes that you would like to discuss with your nurse or doctor today:***

□ Learning to eat less at mealtime
□ Understanding my child's cues of hunger and fullness
□ Increasing fruits and vegetables
□ Eating breakfast every day
□ Improving my child's snacks
□ Improving my child's meals
□ Goals and ideas for dining out
□ Changing what my child drinks
□ Goals for TV, video or computer games
□ Helping my child be more active