

## Nutrition and Activity Screening

Patient Name: \_\_\_\_\_ DOB \_\_\_\_\_ Date: \_\_\_\_\_

**Dear Parent: Please answer these questions about your child's diet and activity.  
Thank you for your time.**

What your child eats:

- Breakfast: \_\_\_\_\_
- Lunch: \_\_\_\_\_
- Supper: \_\_\_\_\_

Snack Foods:

- How many snacks does your child eat on typical day? \_\_\_\_\_
- What are the usual snacks your child eats? \_\_\_\_\_

Vitamins:

- Does your child take a daily multivitamin or supplement? Yes                  No

Drinks:

- How many glasses of the following does your child drink on a typical day?

Milk: \_\_\_\_\_ Kind of milk? \_\_\_\_\_ Juice (orange, apple, grape, etc): \_\_\_\_\_

Water: \_\_\_\_\_ Fruit Drinks (Hi-C, Lemonade): \_\_\_\_\_ Kool-Aid: \_\_\_\_\_ Soda: \_\_\_\_\_

Sweet Tea: \_\_\_\_\_ Other: \_\_\_\_\_ Please List: \_\_\_\_\_

Restaurants:

- How many times in the past 7 days did your child eat or have take-out food from a restaurant? \_\_\_\_\_
- What did they eat? \_\_\_\_\_

Fruits and Vegetables:

- How many servings of fruit does your child usually eat on a typical day? \_\_\_\_\_
- List some of the fruits: \_\_\_\_\_
- How many servings of vegetables does your child usually eat on a typical day? \_\_\_\_\_
- List some of the vegetables: \_\_\_\_\_

Activity:

- How many hours of active play does your child have on a typical weekday? \_\_\_\_\_
- How many hours of active play do your child have on a typical weekend day? \_\_\_\_\_

Television:

- How many hours of TV/Computer/Video Games does your child watch on a typical weekday? \_\_\_\_\_
- How many hours of TV/Computer/Video Games does your child watch on a typical weekend? \_\_\_\_\_
- Does your child have a TV in his/her bedroom? Yes                  No