### ACTIVITY

**On average, how many days per week** does your child get at least 60 minutes of moderate to vigorous physical activity or play (heart beating faster than normal, breathing harder than normal)?

| Days per week: |       |

**On most days of the week** does your child:

- Walk or bike to school? [ ] yes [ ] no
- Participate in physical education class at school? [ ] yes [ ] no
- Participate in organized physical activity (sports, dance, martial arts, etc.) or spend 30 minutes or more playing outside? [ ] yes [ ] no

**On average, how many hours per day** of recreational screen time (video games, TV, Internet, phone, etc.) does your child get?

| Hours per day: |       |

Is physical activity an area that you want to work on with your family to improve? [ ] yes [ ] no

### FOOD

**On average, how many days per week** does your child eat a healthy breakfast?

| Days per week: |       |

**On average, how many servings of fruits and vegetables** does your child eat each day?

| Total servings per day: |       |
| Fruits: |      |
| Veggies: |      |

**On average, how many 12-ounce servings of sweetened drinks** (soda, sports drinks, chocolate milk) does your child have each day?

| Servings per day: |       |
| Servings per week: |       |

**On average, how many servings of dairy** does your child have each day?

| Servings per day: |       |

**On average, how many times per week** do you eat a meal together as a family?

| Times per week: |       |

**On average, how many snacks** does your child have per day?

| Snacks per day: |       |

**On average, how many times per week** does your child eat fast food?

| Times per week: |       |

How often does your child eat while doing other things like watching TV? [ ] rarely [ ] sometimes [ ] often

Does your child ever eat in secret? [ ] yes [ ] no

Is food an area that you want to work on with your family to improve? [ ] yes [ ] no
SLEEP & SUPPORT

Over the past two weeks, how many hours of sleep per day has your child had? (including naps?)

hours per day: _____

Does your child often feel tired, fatigued, or sleepy during the daytime? □ yes □ no

Are there any screens in your child’s bedroom (phone, TV, computer, game console)? □ yes □ no

Does your child snore? □ yes □ no

Has your child stopped breathing while asleep? □ yes □ no

Has your child experienced bullying? □ yes □ no

Does your child have a best friend? □ yes □ no

Who do you (parent) most commonly talk to or go to for help when you do not feel well or you are distressed? (check all that apply)

☐ I usually don’t talk to anyone
☐ I talk to a friend, clergyman, church leader, spouse, or partner
☐ My support is exhausted or burnt out

Is sleep or support an area that you want to work on with your family to improve? □ yes □ no

WEIGHT

Do you think your child is:

☐ underweight  ☐ about right  ☐ overweight

Has your child done anything to try to change their weight before? □ yes □ no

If yes, answer the questions below:

• What methods were used? ____________________________________________________________
• Were they successful? □ yes □ no  □ Why or why not?
• Has your child taken medication or supplements for weight loss? □ yes □ no
  – If yes, what did your child take: ____________________________________________________
  – How long did your child take it? ____________________________________________________
  – Is your child currently taking the medication or supplement? □ yes □ no
  – List any weight change __________________________________________________________
  – List any side effects (dizziness, upset stomach, etc.) _________________________________

Is anyone else in your child’s family currently overweight? □ yes □ no

Is weight an area that you want to work on with your family to improve? □ yes □ no

OTHER LIFESTYLE RISK FACTORS AND CONDITIONS

Does your child have any of the following health conditions?

☐ heart disease  ☐ high cholesterol  ☐ obstructive sleep apnea
☐ high blood pressure  ☐ type 2 diabetes  ☐ depression

Do any of your child’s immediate family members have any of the following, and if so, who?

☐ heart disease – who: _______________________  ☐ obesity – who: _______________________

☐ diabetes – who: ___________________________  ☐ depression – who: ______________________

List all medications or supplements your child takes: _________________________________________

________________________________________________________

What other concerns do you have about your child’s health or health habits? _______________________

________________________________________________________