LiVe Well

Lifestyle and Health Risk Questionnaire

FOR CHILDREN AND ADOLESCENTS

Child's name: _____ Age: _____ Sex: _____ Date: _____

Provider notes: Height (inches): _____ Weight (pounds): _____ BMI: _____ BMI percentile: _____

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: _____/day; veggies:_____/day)	
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

Provider notes:

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SLEEP & SUPPORT

How many **hours of sleep** does your child typically get (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? _____

_____

Provider notes: