Patient Name: _____

Date of Birth: _____ / _____ / _____

Medical Record Number: _____

Health Habits Assessment

Circle one answer for each question. There is no right or wrong answer.

1. How many days a week do you **eat breakfast**?
   A. 7 days **B.** 5-6 days **C.** 3-4 days **D.** 2 days or fewer
2. How many fruits and vegetables do you eat in a day?
   A. 5 or more a day **B.** 3-4 a day **C.** 1-2 a day **D.** Usually none
3. How much juice, soda (Coke®, 7UP®, etc.), or sweetened drinks (Gatorade®, Kool-Aid®, etc.) do you drink in a day?
   A. Less than 1 cup a day **B.** 1 cup a day **C.** 2-3 cups a day **D.** More than 3 cups a day
4. How many meals each week does your family eat at home together?
   A. More than 7 meals a week **B.** 5-6 meals a week **C.** 2-4 meals a week **D.** Less than 2 meals a week
5. How much time (outside of school and work) do you spend watching a screen (TV, computer, video games, GameBoy®, etc.)?
   A. Less than 1 hour a day **B.** 1-2 hours a day **C.** 3-4 hours a day **D.** More than 4 hours a day
6. How many hours a day are you physically active (walking, running, playing, riding a bike, dancing, playing sports, etc.)?
   A. More than 2 hours a day **B.** 1-2 hours a day **C.** ½-1 hour a day **D.** Less than ½ hour a day
7. How many hours of sleep do you get each night?
   A. 8-10 hours a night **B.** 6-7 hours a night **C.** 5 hours a night or less
8. Do you have any concerns about your weight?
   A. Yes **B.** No
9. If you answered "Yes" to question 8, please respond: I would like to _____
   A. weigh less than I do now. **B.** weigh more than I do now. **C.** stay the same weight.

Questions 1-9 completed by: ☐ Patient (child/teen) ☐ Parent, legal guardian or caregiver

---

PARENT, LEGAL GUARDIAN OR CAREGIVER:

1. Are you concerned about your child's weight? ☐ **Yes** ☐ **No**
2. On a scale of 0-10, with 10 being very willing, how **willing (interested, motivated)** are you to make changes toward a healthier lifestyle?
   ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
   not at all willing **somewhat willing** **very willing**
3. On a scale of 0-10, with 10 being very sure, how **sure** are you that you could be successful at making some healthy lifestyle changes now?
   ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
   not at all sure **somewhat sure** **very sure**

_____ _____/_____/_____

Signature of Person(s) Completing Form Relationship Date

PROVIDER USE ONLY:

☐ Sick Visit ☐ Well Visit BMI: _____ BMI Percentile: _____%

Weight Status: ☐ Underweight ☐ Normal Weight ☐ Overweight (DX: 278.00 & V85.53) ☐ Obese (DX: 278.00 & V85.54)

Ethnicity: ☐ Caucasian ☐ African/American ☐ Hispanic/Latino ☐ Asian ☐ Other: _____

Education Provided: ☐ 7 Healthy Lifestyle Tips ☐ Action Cards ☐ Action Plan ☐ Other: _____

Action Plan: Pt made goal to:

☐ Increase activity:_____ ☐ Decrease sweet drinks: _____

☐ Decrease screen time: _____ ☐ Increase family meals: _____

☐ Eat breakfast: _____ ☐ Get more sleep: _____

☐ Increase fruits and vegetables: _____ ☐ Other: _____

Follow Up: Will reassess in _____ weeks/months

_____ _____/_____/_____

Signature Printed Name Date