Healthy Habits Survey

We are interested in the health and well-being of all our patients. Please take a moment to answer the following questions.

Patient name: ______________________ **Age:** ______________ **Date:** __________

		True	False
5	I/my child eats fruits and vegetables 5 or more times a day.	❑	❑
	I/my child eats breakfast every day.	❑	❑
	I/my child eats dinner at the table with the family at least 2 times per week.	❑	❑
2	I/my child watches TV, videos, or plays computer games less than 2 hours per day.	❑	❑
	I/my child has a TV in the bedroom.	❑	❑
	I/my child has a computer in the bedroom.	❑	❑
1	I/my child spends time in active play / being physical active (faster breathing/heart rate or sweating) for at least 1 hour every day.	❑	❑
0	I/my child drinks skim/nonfat milk or 1% rather than 2% or whole milk.	❑	❑
	I/my child regularly drinks juice, soda or punch.	❑	❑

Based on your answers to the questions above, is there ONE thing you would like to change / help your child change now?

- ❑ Eat more fruits and vegetables
- ❑ Drink less soda, juice, or punch
- ❑ Switch to skim or low-fat milk
- ❑ Drink more water
- ❑ Eat less fast food / takeout
- ❑ Eat breakfast every day
- ❑ Spend less time watching TV, sitting and playing video/computer games
- ❑ Take the TV and/or computer out of the bedroom
- ❑ Play outside more often

Please give the completed form to your physician. Thank you.

My/child's personal health goal is to:

Parent/Guardian signature: ______________________ **Clinician signature:** ____________________

Adapted by the Foundation for Healthy Communities from the Maine Center for Public Health Keep ME Healthy Project and High Five for Kids in Massachusetts.