Healthy Lifestyles Survey

Patient Label Here

Age: _____ Grade in school _____

Self Reported Race/Ethnicity
Hispanic African-American Caucasian/White Far-East/Asian
Pacific-Islander Other_____

1. How many people in your immediate family (dad, brother, sister, mother, grandparents) have trouble with being overweight?_____
2. On an average day, how many **hours per day** do you spend:

	WEEKDAY	WEEKEND
Watching TV:	_____	_____
On the computer:	_____	_____
Playing video games:	_____	_____
Talking or texting on cell phone:	_____	_____
Reading books:	_____	_____
Vigorous physical activity:	_____	_____

Do you have a TV in your room? Yes No

3. Has your doctor told you that you have any illnesses related to your weight? (ie diabetes, high blood pressure, sleep apnea, etc.) If yes, what are they?_____

4. How many **days per week** do you eat breakfast? (please circle)

1 2 3 4 5 6 7

5. On average, how many **days per week** do you eat out at:

	Fast Food	Other restaurant
Breakfast:	_____	_____
Lunch:	_____	_____
Dinner:	_____	_____

6. How many days a week do you skip a meal (including breakfast)? _____

7. Who prepares meals at home? (Please Circle)

Self Mom Dad Sibling Other_____

8. How many dinners a week are spent sitting down together as a family? _____

(How many of those are without TV?_____)

9. Who generally does the shopping for food in the household?

Self Mom Dad Sibling Other:_____

8. How many **days per week** do you engage in activity (for at least 30 minutes) that makes you BREATHE HARD , SWEAT, and INCREASE YOUR HEART RATE?

1 2 3 4 5 6 7

How many of these days are from participating in PE?_____

9. How do you get to and from school (ex. Car, Walk, Bike..)?_____

10. On average, how many servings (cans or 8oz glasses) of the following beverages do you drink **per day**?

a. Soda _____ c. Juice _____

b. Diet Soda_____ d. Water_____

11. What is your idea of a healthy lifestyle?_____

_____

_____

12. On a scale of 1-10 (1 being not important & 10 being very important), how important is it to you for your child to have a healthy weight? (Please Circle)

1-2 3-4 5-6 7-8 9-10

13. On a scale of 1-10 (1 being not confident & 10 being very confident), how confident are you that your child can attain a healthy weight and maintain it successfully? (Please Circle)

1-2 3-4 5-6 7-8 9-10

14. What do you think will be most challenging about making changes to the family's healthy lifestyle? (Please Circle)

Limited time Limited family support Limits in transportation Other_____

_____