Children's Hospital
Greenville Health System
New Impact

Healthy Behavior Questionnaire

Patient Name: _____

DOB: _____ Date: _____

Email address: _____

Nutrient Dense Foods

1. How many servings per **day** are you eating the following food categories?
    a. Starchy vegetables (e.g. potatoes, dried beans, peas or corn)?

    _____

    b. Non-starchy vegetables (e.g., broccoli, carrots, green beans or tomatoes)?

    _____

    c. Fruit?

    _____

    d. Whole grains (e.g., whole wheat bread, brown rice or oatmeal)?

    _____

    e. Lean proteins (e.g., grilled chicken, extra lean 95/5 ground beef)?

    _____

    f. Dairy (e.g., low fat milk, yogurt or cheese)?

    _____

        i. What type of milk do you typically keep at home?

        _____

2. Do you keep fresh fruits and vegetables available in the home?
    a. Yes _____ No _____

Calorie Dense Foods

3. How many servings per **day** are you eating the following food categories?

    a. Fried foods (e.g., potato chips, French fries or fried meats)?

    _____

    b. Sweets (e.g., candy, ice cream, cookies, or brownies)?

    _____

    c. Fatty proteins (e.g., hot dogs, sausage, pepperoni or chicken nuggets)?

    _____

4. How many sugary drinks (e.g., juice, chocolate milk, Gatorade, sweet tea or soda) do you consume per **day**?

    _____

5. How many sugary drinks does the **parent** drink per **day**?

    _____

6. Do you keep high fat or high sugar foods (e.g., potato chips, cookies, snack cakes, ice cream, or frozen fried foods) available in the home?

    d. Yes _____ No _____

Meal Patterns

7. Do you eat breakfast every day? Yes _____ No _____

    a. If yes, what do you typically have? If no, what is your main reason for not eating breakfast?

    _____

    _____

    _____

    _____

8. How many meals do you eat each **day**?

   _____

9. What meals do you consume at school? Breakfast ____ Lunch ____ Snacks ____

   a. What do you get to drink at school meals?

      _____

10. How often do you eat outside of the house (e.g., fast food, restaurants or social gatherings) in an average week?

    _____

    a. Do you try to choose healthy options when eating out? Yes ____ No _____

    b. Do you eat meals or snacks in front of the TV/computer? Yes ____ No _____

11. Do you eat when you are not hungry? Yes _____ No _____

    a. If yes, what causes it (e.g, boredom, sadness or nervousness)?

       _____

       _____

24 Hour Diet Recall

12. Please provide a 24 hour recall. List everything you ate yesterday including condiments and preparation method for all meals and snacks.

    a. *Example for breakfast: 1 piece whole wheat toast with 1 tablespoon of butter, 2 scrambled egg whites prepared with non-fat cooking spray with low fat cheese, 2 pieces of turkey bacon, and 8 oz of orange juice.*

    b. What did you eat for breakfast?

       _____

       _____

       _____

       _____

i. What did you have to drink?

_____

c. Did you have a snack or any drinks between breakfast and lunch?

_____

_____

_____

d. What did you eat for lunch?

_____

_____

_____

_____

i. What did you have to drink? _____

e. Did you eat a snack or have any drinks between lunch and dinner?

_____

_____

_____

f. What did you have for dinner?

_____

_____

_____

_____

i. What did you have to drink? _____

g. Did you eat a snack or have any drinks after dinner?

_____

_____

_____

13. Was the above day how you typically eat? Yes _____ No _____

    a. If no, what is different?

_____

_____

_____

_____

Physical Activity

1. How many hours per day do you spend doing mild to moderate activities (e.g., walking, gardening, or household chores)?

    a. For the child: _____

    b. For the parent: _____

2. How many hours per day do you spending doing activities that cause increased heart rate and make breathing harder (e.g., running, swimming, biking, dancing, or playing basketball, football, or soccer)?

    a. For the child: _____

    b. For the parent: _____

Sedentary Behavior

3. How many hours per day do you spend lying down, sitting down, or napping (e.g., watching TV, computer time, reading, video games or sitting at a desk)?

    a. For the child: _____

    b. For the parent: _____

4. List any specific nutrition goals that you would like to accomplish.

_____

_____

_____

_____

5. Are you worried about being able to make better food choices? Yes _____ No _____

    a. If yes, what will be hard for you?

    _____

    _____

    _____

    _____

6. Please list any other concerns or important information you would like the dietitian to be aware of prior to your first visit.

_____

_____

_____

_____