

What do you eat?

What did you eat yesterday? List everything you ate and drank. How much? What time?

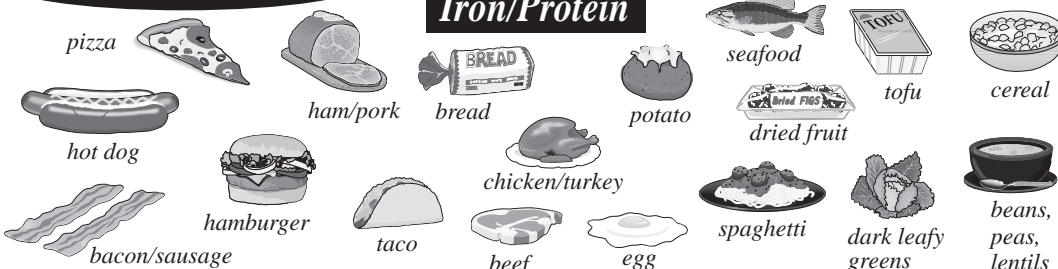
Time Amount Food or Drink

10:00 a.m. ½ cup Carrots

Was yesterday a typical day? ____ Yes ____ No

Circle the foods you eat often.

Iron/Protein



For office use only

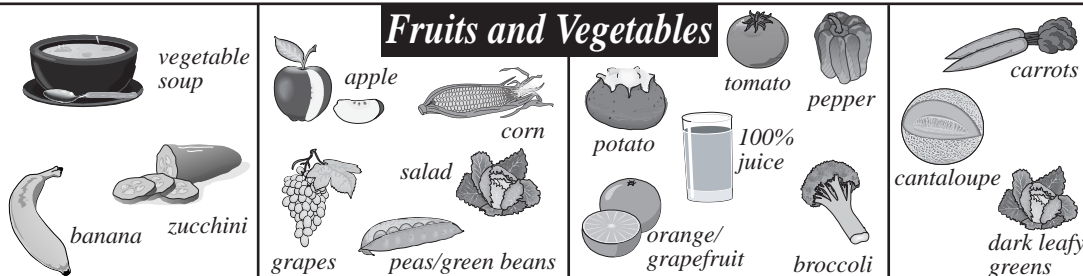
(Check (✓) topics discussed)

- ☐ Continue eating healthy
- ☐ ↑ regular meals/snacks
- ☐ Encourage breakfast
- ☐ Inadequate food supply
- ☐ Encourage lower fat
- ☐ Encourage lower sugar
- ☐ Weight management
- ☐ Disordered eating
- ☐ Other _____

Iron/Protein

- ☐ 2 - 3 servings daily
- ☐ ↑ high iron foods
- ☐ ↑ alternate protein sources for vegetarian diets
- ☐ ↑ beans, lentils, peas
- ☐ Limit high fat meats

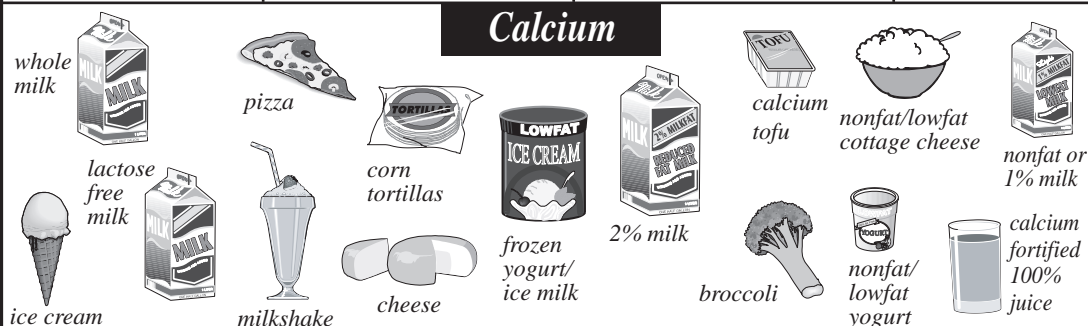
Fruits and Vegetables



Fruits and Vegetables

- ☐ 2 - 4 Fruits daily or more
- ☐ 3 - 5 Vegetables daily or more
- ☐ Vitamin C sources
- ☐ Vitamin A sources

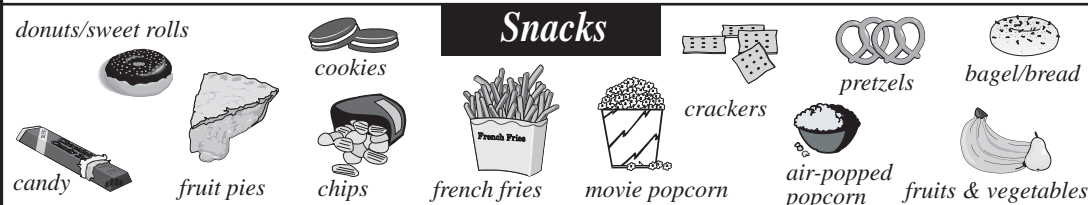
Calcium



Calcium

- ☐ 3 - 4 servings daily
- ☐ Encourage nonfat or 1% milk
- ☐ ↓ high fat choices
- ☐ ↑ low lactose alternatives
- ☐ ↑ calcium-fortified foods

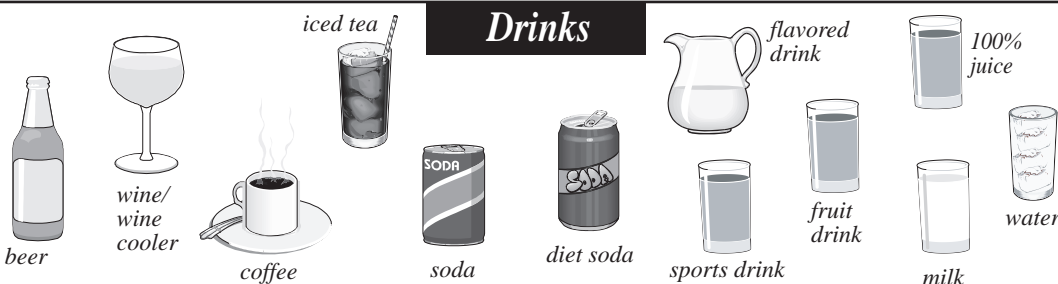
Snacks



Snacks

- ☐ ↓ high sugar snacks
- ☐ ↓ high fat snacks
- ☐ ↑ fruit/vegetable snacks
- ☐ ↓ fast food

Drinks



Drinks

- ☐ Limit juice: 1/day (4-8 oz. total)
- ☐ Drink 100% juice
- ☐ Drink 8-12 glasses water/day (8 oz. each)
- ☐ Discourage fruit drinks
- ☐ Discourage soda/caffeine
- ☐ Discourage alcohol

Name _____ Age _____ Date of Birth _____ Date _____

Youth Nutrition and Activity Assessment

(Ages 8-21)

Provide additional information on your food, activity and health habits.

Health professionals: Complete assessment in the shaded boxes below using all information provided.

Eating Habits:

Do you eat or drink:	Yes	No	Examples/Comments
▶ breakfast?	<input type="checkbox"/>	<input type="checkbox"/>	_____
▶ morning snack?	<input type="checkbox"/>	<input type="checkbox"/>	_____
▶ lunch?	<input type="checkbox"/>	<input type="checkbox"/>	_____
▶ afternoon snack?	<input type="checkbox"/>	<input type="checkbox"/>	_____
▶ dinner?	<input type="checkbox"/>	<input type="checkbox"/>	_____
▶ evening snack?	<input type="checkbox"/>	<input type="checkbox"/>	_____
▶ milk?	<input type="checkbox"/>	<input type="checkbox"/>	_____
▶ soda, coffee, tea?	<input type="checkbox"/>	<input type="checkbox"/>	_____
▶ beer, wine or other alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	_____

Eating Habits:

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Is the overall diet adequate? Does it include:
		<input type="checkbox"/> 3 meals/2 snacks
		<input type="checkbox"/> high iron foods
		<input type="checkbox"/> calcium foods
		<input type="checkbox"/> 5 or more fruits and vegetables
		<input type="checkbox"/> adequate fluids
<input type="checkbox"/>	<input type="checkbox"/>	Is hgb/hct within normal limits?
<input type="checkbox"/>	<input type="checkbox"/>	Has there ever been a lead test? _____
<input type="checkbox"/>	<input type="checkbox"/>	Counseling given (topics): _____

<input type="checkbox"/>	<input type="checkbox"/>	Further counseling needed (topics): _____

<input type="checkbox"/>	<input type="checkbox"/>	Referral made to: _____

Exercise/Physical Activity:

▶ How many hours per day do you:

▶ watch TV? _____ hours per day

▶ play video/computer games? _____ hours per day

▶ surf the internet/chat rooms? _____ hours per day

▶ (Circle all that apply) Do you walk, run, bicycle, rollerblade or dance? Do you play basketball, softball, soccer, volleyball, other team sports?

▶ Do you participate in physical education classes at school?
☐ Yes ☐ No

▶ Other activities _____

▶ How often are you physically active?
 _____ times per week _____ minutes each time

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Limit use of TV/computer/video/internet (1-2 hours/day or less) Goals set? _____

<input type="checkbox"/>	<input type="checkbox"/>	Encourage activity (60 minutes/day or more) Goal set? _____

<input type="checkbox"/>	<input type="checkbox"/>	Referral made to: _____

Weight/Body Image:

▶ Are you trying to:
☐ lose weight ☐ gain weight ☐ stay the same?

▶ Do you eat less to control your weight? ☐ Yes ☐ No
 Explain: _____

▶ Have you ever made yourself vomit? ☐ Yes ☐ No
 If yes, how often? _____ When was the last time? _____

▶ Do you ever "binge" eat? ☐ Yes ☐ No
 If yes, how often? _____ When was the last time? _____

▶ Are you currently using diet pills, laxatives, supplements, steroids, protein powders? ☐ Yes ☐ No

▶ Other products used _____

BMI _____ Date _____

☐ Acceptable Range BMI between 5th and 85th percentile

☐ At risk of overweight BMI for age > 85th percentile, < 95th percentile

☐ Overweight BMI for age ≥ 95th percentile

☐ Underweight BMI for age ≤ 5th percentile

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	General signs of an eating disorder?
<input type="checkbox"/>	<input type="checkbox"/>	Understands healthy eating?
<input type="checkbox"/>	<input type="checkbox"/>	Counseling given?
		Topics: _____

<input type="checkbox"/>	<input type="checkbox"/>	Referral made to: _____

Completed by Name/Title: _____ Date: _____