

Name _____

Date of Birth ____/____/____ Date ____/____/____





Health Habits Assessment & Plan

(Youth 12+)



A. WHAT ARE YOUR HEALTH HABITS?

Please mark the boxes with the answers true for most days.

| | | | | | |
|--|--|--------------------------------|---|--|--|
|  | 1. How many servings of FRUITS AND VEGETABLES do you eat a day? | <input type="checkbox"/> 0 | <input type="checkbox"/> 1-2 | <input type="checkbox"/> 3-4 | <input type="checkbox"/> 5 or more |
|  | 2. Outside of school, how many hours a day do you sit in front of a SCREEN (TV, computer, video game, phone)? | <input type="checkbox"/> 0 | <input type="checkbox"/> 1-2 | <input type="checkbox"/> 3-4 | <input type="checkbox"/> 5 or more |
|  | 3. On most days, how many hours do you spend in ACTIVE PLAY (fast breathing, sweating)? | <input type="checkbox"/> 0 | <input type="checkbox"/> 30 minutes | <input type="checkbox"/> 1 hour | <input type="checkbox"/> 2 or more hours |
|  | 4. How many servings of SODA or sugary drinks (fruit juice, sweet tea, sports drinks) do you drink each day? (1 serving = 6 oz. = 3/4 cup = 1/2 can of soda) | <input type="checkbox"/> 0 | <input type="checkbox"/> 1-2 (up to 1 1/2 cups or 1 can) | <input type="checkbox"/> 3-4 (up to 3 cups or 2 cans) | <input type="checkbox"/> 5 or more |
| | 5. How many SNACKS like cookies, ice cream, candy or chips do you get each day? | <input type="checkbox"/> 0 | <input type="checkbox"/> 1-2 | <input type="checkbox"/> 3-4 | <input type="checkbox"/> 5 or more |
| | 6. How many days a week do you eat BREAKFAST ? | <input type="checkbox"/> 0 | <input type="checkbox"/> 1-2 | <input type="checkbox"/> 3-4 | <input type="checkbox"/> 5 or more |
| | 7. How many times a week do you EAT a meal AT THE TABLE, AT HOME WITH your FAMILY ? | <input type="checkbox"/> 0 | <input type="checkbox"/> 1-2 | <input type="checkbox"/> 3-4 | <input type="checkbox"/> 5 or more |
| | 8. Do you have a TV in the room where you SLEEP ? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | | |
| | 9. What kind of MILK do you drink? | <input type="checkbox"/> Whole | <input type="checkbox"/> 2% | <input type="checkbox"/> Skim or 1% | <input type="checkbox"/> Other |

B. ARE YOU READY TO MAKE CHANGES?

Please circle a number.

| | | | | | | | | | |
|---------|---|---|-------------------|---|---|---|-----------|---|----|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Not yet | | | Thinking about it | | | | Let's go! | | |

C. WHAT WOULD YOU LIKE TO DO?

Please mark one box and write in your goal.



Eat more fruits and vegetables:

_____ servings daily.



Play (sweat and breathe fast) everyday:

_____ minutes.



Set limits on screen time:

_____ hour(s)/daily.



Reduce sugar-sweetened beverages: less than _____ servings a week.

Other: _____

D. WHAT MIGHT MAKE IT HARD TO DO THIS?

Please write your answer on the line below.

E. HOW CONFIDENT ARE YOU THAT YOU CAN MAKE CHANGES?

Please circle a number.

| | | | | | | | | | |
|---------------|---|---|--------------------|---|---|---|----------------|---|----|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Not confident | | | Somewhat confident | | | | Very confident | | |