Name _____

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

# Health Habits Assessment & Plan
(Child 2-11)

five two one almost none

## 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** does your child eat a day? | ☐ 0 | ☐ 1-2 | ☐ 3-4 | ☐ 5 or more |
| 2. Outside of school, how many hours a day does your child sit in front of a **SCREEN** (TV, computer, video game, phone)? | ☐ 0 | ☐ 1-2 | ☐ 3-4 | ☐ 5 or more |
| 3. On most days, how many hours does your child spend in **ACTIVE PLAY** (fast breathing, sweating)? | ☐ 0 | ☐ 30 minutes | ☐ 1 hour | ☐ 2 or more hours |
| 4. How many servings of **SODA** or sugary drinks (fruit juice, sweet tea, sports drinks) does your child drink each day? (1 serving = 6 oz. = ¾ cup = ½ can of soda) | ☐ 0 | ☐ 1-2 (up to 1½ cups or 1 can) | ☐ 3-4 (up to 3 cups or 2 cans) | ☐ 5 or more |
| 5. How many **SNACKS** like cookies, ice cream, candy or chips does your child get each day? | ☐ 0 | ☐ 1-2 | ☐ 3-4 | ☐ 5 or more |
| 6. How many days a week does your child eat **BREAKFAST**? | ☐ 0 | ☐ 1-2 | ☐ 3-4 | ☐ 5 or more |
| 7. How many times a week does your child **EAT** a meal **AT THE TABLE AT HOME WITH** the **FAMILY**? | ☐ 0 | ☐ 1-2 | ☐ 3-4 | ☐ 5 or more |
| 8. Does your child have a **TV** in the room where s/he **SLEEPS**? | ☐ Yes | ☐ No | | |
| 9. What kind of **MILK** does your child drink? | ☐ Whole | ☐ 2% | ☐ Skim or 1% | ☐ Other |

## B. ARE YOU READY TO MAKE CHANGES?

Please circle a number.

1 2 3 — Not yet

4 5 6 7 — Thinking about it

8 9 10 — 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.

☐ Set limits on screen time: _____ hour(s)/daily.

☐ Play (sweat and breathe fast) everyday: _____ minutes.

☐ 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 — Not confident

4 5 6 7 — Somewhat confident

8 9 10 — Very confident

Adapted by WNC Healthy Kids from NICHQ, The Nemours Foundation, and Eat Smart Move More NC