

# What do you eat?

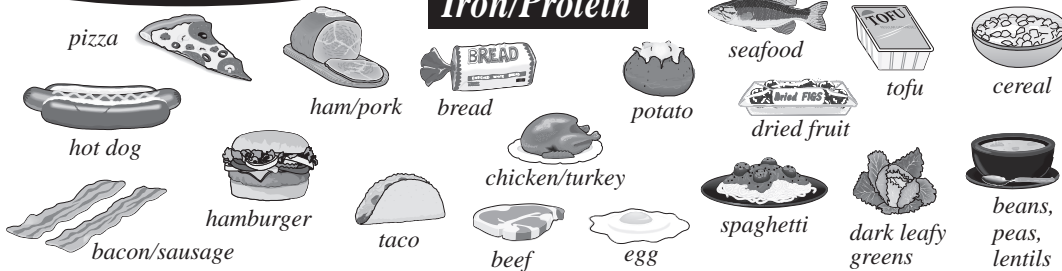
What did you eat yesterday? List everything you ate and drank. How much? What time?

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

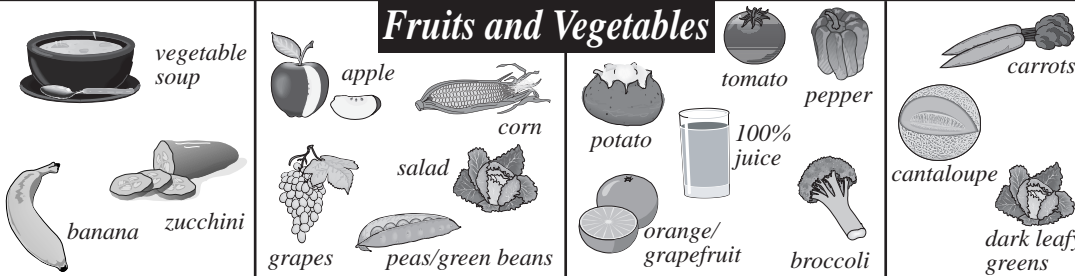
(Check (✓) topics discussed)

- 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

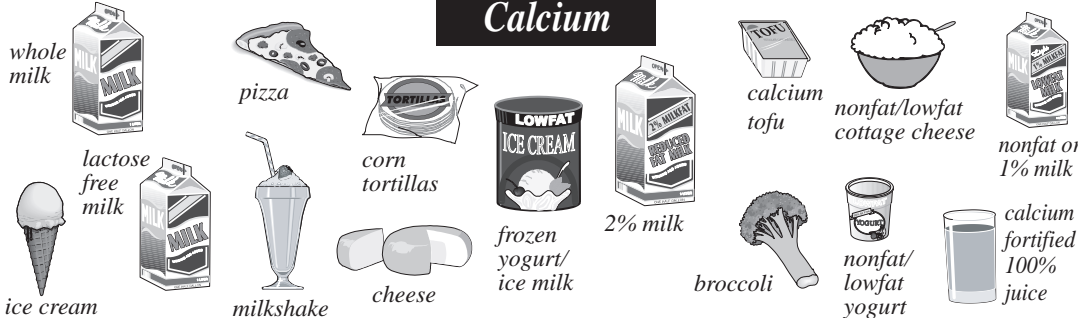
## Fruits and Vegetables



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

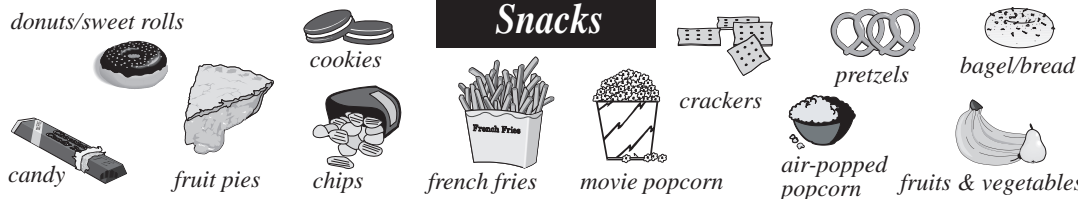
## Calcium



## Calcium

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

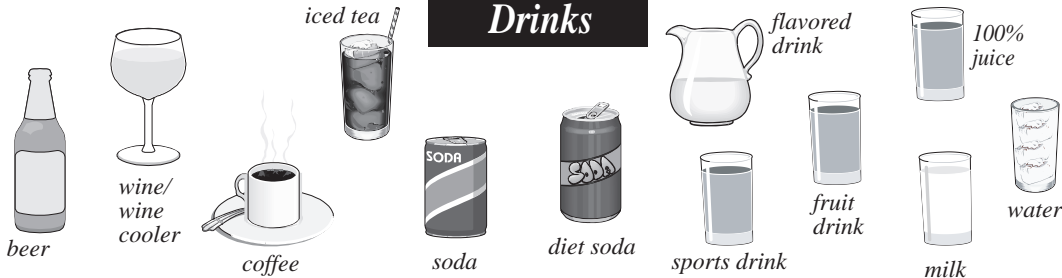
## Snacks



## 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:** \_\_\_\_\_