What Do You Eat? – Food Frequency Questionnaire

(Ages 8-19)

Circle the names of foods you eat often:

Iron/Protein

Chicken/Turkey Beef Ham/Pork Seafood Eggs Tofu
Hot dog Hamburger Fried Chicken Pizza Tacos
Meat/Bean Burrito Pasta Spaghetti with Meatballs
Peanut Peanut Butter Rice Noodle Soup Beans/Lentils
Tortilla White Bread Whole Grain Bread Cereal
Sweet Bread Potato Dark Green Leafy Vegetables

Fruits and Vegetables

Apple Banana Grapes Pear Peach 100% Juice
Strawberry Pineapple Orange Cantaloupe Melon
Bell pepper Chili pepper Tomato Green Salad Cucumber
Mango Broccoli Cabbage Dark Green Leafy Vegetables
Carrot Peas Green Beans Corn Potato Sweet Potato

Snack

Cookies Fruit Pie Donut Candies Chocolate
Chips Cheese Puffs French Fries Mexican Bread
Popcorn Bagels Pretzels Crackers Fruits Vegetables

Drinks

Water 100% Fruit Juice Soda Fruit Flavored Soda
Sports Drinks Energy Drinks Flavored Drinks
Coffee Coffee Drink Tea Sweetened Tea Herbal Tea
Beer Wine Wine Cooler Alcoholic Drink

Calcium

Nonfat Milk 1 % Lowfat Milk 2 % Milk Whole Milk
Lactose Free Milk Cheese Cottage Cheese Yogurt
Milkshake Ice Cream Calcium Fortified Soy/Plant Milk
Calcium Fortified 100% Juice Tofu Tempeh Soy Beans
Green Leafy Vegetables Dried Figs Prunes Orange
Almonds Almond butter Tahini Beans Corn Tortilla

Name: ______________________ **Age:** _____ **Date of Birth:** _________

Wt: _____ lbs **Ht:** _____ in **BMI:** _____ **BMI %ile:** _____ **Date:** ______

Office use only:

Circle to indicate the topics discussed:

Healthy eating
Regular meals/snacks
Importance of breakfast
Inadequate food supply
Low fat dairy foods
High sugar foods
Other: ____________________________

Iron/Protein

2-3 servings daily
High iron foods
Plant protein sources such as
beans, peas, lentils, nuts, etc.
Limit high fat foods

Fruits and Vegetables

2-4 fruits daily or more
3-5 vegetables daily or more
Vitamin C sources
Vitamin A sources

Calcium

3-4 servings dairy foods/day
Nonfat or 1 % milk
Lowfat dairy choices
Low lactose alternative
Calcium fortified foods
Other food sources of calcium

Snacks

High-sugar snacks
High-fat snacks
Fruit/vegetable snacks
Fast foods

Drinks

< 8-12 oz/day 100% juice
6-8 glasses of water (8 ounces each)/day
Sweetened drinks
Alcohol/caffeine

Referred for identified nutrition problem? **Yes** **No**

If yes, where: ________________________

Provider initials: _____________________

DHCS 4466 (05/16) Adapted from the CHDP Programs of Orange County and San Bernardino Counties

What Do You Eat? – Youth Nutrition and Activity Assessment

(Ages 8 - 19)

Provide additional information about your food, activity and habits:

Eating Habits

Do you eat or drink the following meals? Circle one answer per meal.

Meal				
Breakfast	**Always**	**Usually**	**Occasionally**	**Never**
Morning snack	**Always**	**Usually**	**Occasionally**	**Never**
Lunch	**Always**	**Usually**	**Occasionally**	**Never**
Afternoon snack	**Always**	**Usually**	**Occasionally**	**Never**
Dinner	**Always**	**Usually**	**Occasionally**	**Never**
Evening Snack	**Always**	**Usually**	**Occasionally**	**Never**

Exercise/Physical Activity

How many hours a day do you?

- Watch TV _____ hours/day
- Use a smart phone _____ hours/day
- Play video/computer games _____ hours/day
- Use the internet _____ hours/day

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

Circle all that you participate in:

Walking	Running	Bicycling	Swimming
Dance	Yoga	Martial Arts	Rollerblading
Basketball	Softball	Soccer	Volleyball

Other activities or team sports: ______________________________

How often are you physically active?

_____ times/week _____ minutes/day

Weight/Body Image

Circle one. Are you trying to?

Stay the same Lose weight Gain weight Not concerned

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? ________

Circle any of the following that you use:

Diet pills	Laxatives		
Multivitamins	Calcium	Iron	Vitamin D
Protein powder	Nutrition supplements		Steroids

What, if any, other products do you use?

Explain: ____

Office use only

Complete assessment below using all information provided:

Eating Habits

Overall diet adequate	**Yes**	**No**
3 meals and snacks	**Yes**	**No**
High iron foods	**Yes**	**No**
Calcium foods	**Yes**	**No**
5 or more fruits/vegetables	**Yes**	**No**
Adequate fluids	**Yes**	**No**

Exercise/Physical Activity

Limits use of TV, phone, internet, video or computer games to ≤ 1-2 hours/day **Yes** **No**

Goal set: ______________________

Engages in physical activity (60 minutes/day or more) **Yes** **No**

Goal set: ______________________

Referral made **Yes** **No**

Referred to: ____________________

Weight/Body Image

BMI %ile ________ Date ____________

- ☐ ***BMI between 5th and 85th %iles***
- ☐ ***BMI ≤ 5th %ile***
- ☐ ***BMI between 85th and 95th %iles***
- ☐ ***BMI ≥ 95th %ile***

Signs of eating disorder **Yes** **No**

Counseling given **Yes** **No**

Topics: ______________________

Goal set: ______________________

Referral made **Yes** **No**

Referred to: ____________________