

# 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

Is the overall diet adequate? Does it include:

- 3 meals/2 snacks
- high iron foods
- calcium foods
- 5 or more fruits and vegetables
- adequate fluids

Is hgb/hct within normal limits?

Has there ever been a lead test? \_\_\_\_\_

Counseling given (topics): \_\_\_\_\_

\_\_\_\_\_

Further counseling needed (topics): \_\_\_\_\_

\_\_\_\_\_

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

Limit use of TV/computer/video/internet (1-2 hours/day or less) Goals set? \_\_\_\_\_

\_\_\_\_\_

Encourage activity (60 minutes/day or more) Goal set? \_\_\_\_\_

\_\_\_\_\_

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

General signs of an eating disorder?

Understands healthy eating?

Counseling given?

Topics: \_\_\_\_\_

\_\_\_\_\_

Referral made to: \_\_\_\_\_

\_\_\_\_\_

**Completed by Name/Title:** \_\_\_\_\_ **Date:** \_\_\_\_\_