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Parent Questionnaire: Healthy Eating

Patient Name: _____ Date: _____

1.	Does your child eat five fruits and vegetables daily?	N Y
2.	Does your child eat foods with whole grains and fiber?	N Y
3.	Does your child eat 2-3 servings of dairy daily?	N Y
4.	Does your child drink soda or sugared fruit drinks?	Y N
5.	Does your child eat breakfast daily?	N Y
6.	Does your child eat three meals a day?	N Y
7.	Does your child eat more than two snacks a day?	Y N
8.	Does your child eat Fast Food on a regular basis?	Y N
9.	Does your family eat meals together on a regular basis?	N Y
10.	Does your child eat after dinner and before bedtime?	Y N
11.	Does your child have a TV in his/her room?	Y N
12.	Does your child participate in more than 2 hours of screen time? (TV, computer, texting, etc.)	Y N
13.	Does your child play outside on a daily basis?	N Y
14.	Does your child get physical exercise on a daily basis?	N Y
15.	Are Carbohydrates the main part of your child's diet? (i.e. breads, cereals, pasta, rice, potatoes, etc.)	Y N