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: _____

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.

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: _____