

# 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	<b>Always</b>	<b>Usually</b>	<b>Occasionally</b>	<b>Never</b>
Morning snack	<b>Always</b>	<b>Usually</b>	<b>Occasionally</b>	<b>Never</b>
Lunch	<b>Always</b>	<b>Usually</b>	<b>Occasionally</b>	<b>Never</b>
Afternoon snack	<b>Always</b>	<b>Usually</b>	<b>Occasionally</b>	<b>Never</b>
Dinner	<b>Always</b>	<b>Usually</b>	<b>Occasionally</b>	<b>Never</b>
Evening Snack	<b>Always</b>	<b>Usually</b>	<b>Occasionally</b>	<b>Never</b>

**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	<b>Yes</b>	<b>No</b>
3 meals and snacks	<b>Yes</b>	<b>No</b>
High iron foods	<b>Yes</b>	<b>No</b>
Calcium foods	<b>Yes</b>	<b>No</b>
5 or more fruits/vegetables	<b>Yes</b>	<b>No</b>
Adequate fluids	<b>Yes</b>	<b>No</b>

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