

Name _____

Date ____/____/____

Date of Birth ____/____/____

Healthy Weight Assessment & Plan



A. ASSESSING HABITS



1. How many servings of **FRUITS AND VEGETABLES** does your child eat a day? 5 or more 3-4 2 or less



2. Outside of school, how many hours a day does your child sit in front of a **SCREEN** (TV, computer, video game, phone)? 0 1-2 3-4 5 or more



3. On most days, how many hours does your child spend in **ACTIVE PLAY** (fast breathing, sweating)? 2 or more 1 1/2 0



4. How many servings of **SODA** or sugary drinks (fruit juice, sweet tea, sports drinks) does your child drink each day? (1 serving = 6 oz. = 3/4 cup = 1/2 can of soda) 0 1-2 (up to 1 1/2 c. or 1 can) 3-4 (up to 3 c. or 2 cans) 5-6 (up to 4 1/2 c. or 3 cans) More than 6

5. How many **SNACKS** like cookies, ice cream, candy or chips does your child get each day? 0 1 2 or more

6. How many days a week does your child eat **BREAKFAST**? Everyday Some days Rarely or never

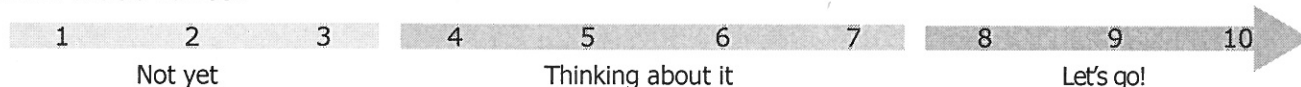
7. How many times a week does your child **EAT** a meal **AT THE TABLE AT HOME WITH** the **FAMILY**? 5 or more 2-4 0-1

8. Does your child have a **TV** in the room where s/he **SLEEPS**? No Yes

9. What kind of **MILK** does your child drink? Skim or 1% 2% Whole None Other: _____

B. ARE YOU READY TO MAKE CHANGES?

Please circle a number.



C. WHAT WOULD YOU LIKE TO DO?



Eat more fruits and vegetables: _____ servings daily.



Play (sweat and breathe fast) everyday: _____ minutes.



Set limits on screen time: _____ hour(s)/daily.



Reduce sugar-sweetened beverages: less than _____ servings a week.

Other: _____

What might make it hard to do this? _____

D. HOW CONFIDENT ARE YOU THAT YOU CAN MAKE CHANGES?

Please circle a number.

