

**Nutrition and Physical Activity Self-Assessment Form**

This questionnaire is to be completed by a patient or their parent or guardian.  
Fill in the blanks below, or scale answers **0 = not at all, 10 = very much**

Patient ID stamp here

1. Are you concerned about your (the patient's) weight?

0 1 2 3 4 5 6 7 8 9 10

2. Are you concerned about your (the patient's) physical appearance?

0 1 2 3 4 5 6 7 8 9 10

3. Are you (the patient) interested in improving your athletic performance, stamina, or flexibility?

0 1 2 3 4 5 6 7 8 9 10

4. Food Choices: How many **times per day** does the patient:

- a. Eat vegetables (excluding french fries) \_\_\_\_\_
- b. Eat fruit \_\_\_\_\_
- c. Eat sweets and/or salty snacks \_\_\_\_\_
- d. Drink pop, juice or sport drinks \_\_\_\_\_
- What type of milk does the patient drink \_\_\_\_\_

5. Meal Patterns: How many **times per week** does the patient:

- a. Eat breakfast \_\_\_\_\_
- b. Eat dinner with the family \_\_\_\_\_
- c. Eat fast food meals \_\_\_\_\_
- d. Eat meals or snacks in front of the TV \_\_\_\_\_
- e. Eat meals or snacks in the car \_\_\_\_\_

6. Physical Activity: How many **days a week** does the patient:

- a. Participate in physical education \_\_\_\_\_
- b. Participate in physical activity (walking, running, playing games, sports, biking, etc.) for a combined total of 60 minutes or more \_\_\_\_\_

7. Screen Time: How many **hours a day** does the patient:

- a. Watch TV \_\_\_\_\_
- b. Use the computer and/or play video games \_\_\_\_\_
- Does the patient have a TV in his/her own room \_\_\_\_\_

8. Are you (the patient and family) prepared to make changes to your eating habits and/or activity patterns?

0 1 2 3 4 5 6 7 8 9 10

9. What activities do you (the patient) most enjoy? \_\_\_\_\_

10. What is your goal for yourself (the patient or for your child)? Please circle below:

- Weight loss
- Weight maintenance
- Improved fitness
- Better self-image

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Clinician _____
Date _____