LiVe Well

Lifestyle and Health Risk Questionnaire

FOR CHILDREN AND ADOLESCENTS

Child's name: ____________________________________________ Age: _____ Sex: _____ Date: ______

Provider notes: Height (inches): _______ Weight (pounds): _______ BMI: _______ BMI percentile: _______

### ACTIVITY

On average, how many days per week does your child get at least 60 minutes of moderate to vigorous physical activity or play (heart beating faster than normal, breathing harder than normal)?

**days per week: __________**

**On most days of the week** does your child:
- Walk or bike to school? □ yes □ no
- Participate in **physical education class** at school? □ yes □ no
- Participate in **organized physical activity** (sports, dance, martial arts, etc.) or spend 30 minutes or more **playing outside**? □ yes □ no

On average, how many hours per day of recreational screen time (video games, TV, Internet, phone, etc.) does your child get?

**hours per day: __________**

Is physical activity an area that you want to work on with your family to improve?

□ yes □ no

### FOOD

On average, how many days per week does your child eat a healthy **breakfast**?

**days per week: __________**

On average, how many servings of **fruits and vegetables** does your child eat each day?

**total servings per day: _______**

(fruits: _______/day; veggies: _______/day)

On average, how many 12-ounce servings of **sweetened drinks** (soda, sports drinks, chocolate milk) does your child have each day?

**servings per day: _______**

**servings per week: _______**

On average, how many servings of **dairy** does your child have each day?

**servings per day: _______**

On average, how many times per week do you eat a meal together as a **family**?

**times per week: _______**

On average, how many **snacks** does your child have per day?

**snacks per day: _______**

On average, how many times per week does your child eat **fast food**?

**times per week: _______**

How often does your child **eat while doing other things** like watching TV?

□ rarely □ sometimes □ often

Does your child ever **eat in secret**?

□ yes □ no

Is food an area that you want to work on with your family to improve?

□ yes □ no
**SLEEP & SUPPORT**

How many hours of sleep does your child typically get (including naps)? hours per day: ____

- Does your child often feel tired, fatigued, or sleepy during the daytime? □ yes □ no
- Are there any screens in your child’s bedroom (phone, TV, computer, game console)? □ yes □ no
- Does your child snore? □ yes □ no
- Has your child stopped breathing while asleep? □ yes □ no
- Has your child experienced bullying? □ yes □ no
- Does your child have a best friend? □ yes □ no

Who do you (parent) most commonly talk to or go to for help when you do not feel well or you are distressed? (check all that apply)
- □ I usually don’t talk to anyone
- □ I talk to a friend, clergyman, church leader, spouse, or partner
- □ My support is exhausted or burnt out

Is sleep or support an area that you want to work on with your family to improve? □ yes □ no

**WEIGHT**

Do you think your child is:
- □ underweight □ about right □ overweight

Has your child done anything to try to change their weight before? □ yes □ no

If yes, answer the questions below:
- What methods were used? ____________________________________________________________
- Were they successful? □ yes □ no □ Why or why not?
- Has your child taken medication or supplements for weight loss? □ yes □ no
  - If yes, what did your child take: ______________________________________________________
  - How long did your child take it? ______________________________________________________
  - Is your child currently taking the medication or supplement? □ yes □ no
  - List any weight change ______________________________________________________________
  - List any side effects (dizziness, upset stomach, etc.) _______________________________________________________________________

Is anyone else in your child’s family currently overweight? □ yes □ no

Is weight an area that you want to work on with your family to improve? □ yes □ no

**OTHER LIFESTYLE RISK FACTORS AND CONDITIONS**

- Does your child have any of the following health conditions?
  □ heart disease □ high cholesterol □ obstructive sleep apnea
  □ high blood pressure □ type 2 diabetes □ depression

- Do any of your child’s immediate family members have any of the following, and if so, who?
  □ heart disease – who: ____________________________________
  □ obesity – who: _________________________________________
  □ diabetes – who: ________________________________________
  □ depression – who: ______________________________________

- List all medications or supplements your child takes: _______________________________________

- What other concerns do you have about your child’s health or health habits? __________________________________________________________________________