North Dallas Pediatric Associates

Child's Name ______________________________ **DOB:** ______________

Nutrition Questionnaire for Adolescents, Ages 11 - 21

1. Which of these meals or snacks did you eat yesterday? *(Check all that apply.)*
   - ☐ Breakfast
   - ☐ Lunch
   - ☐ Dinner or supper
   - ☐ Morning snack
   - ☐ Afternoon snack
   - ☐ Evening/late-night snack

2. Do you skip breakfast 3 or more times a week?
   ☐ Yes ☐ No
   Do you skip lunch 3 or more times a week?
   ☐ Yes ☐ No
   Do you skip dinner or supper 3 or more times a week?
   ☐ Yes ☐ No

3. Do you eat dinner or supper with your family 4 or more times a week?
   ☐ Yes ☐ No

4. Do you fix or buy the food for any of your family's meals?
   ☐ Yes ☐ No

5. Do you eat or take out a meal from a fast-food restaurant 2 or more times a week?
   ☐ Yes ☐ No

6 Are you on a special diet for medical reasons?
   ☐ Yes ☐ No

7. Are you a vegeterian?
   ☐ Yes ☐ No

8. Do you have any problems with your appetite, like not feeling hungry, or feeling hungry all the time?
   ☐ Yes ☐ No

9. Which of the following did you drink last week? *(Check all that apply.)*
   - ☐ Tap or bottled water
   - ☐ Fitness water
   - ☐ Juice
   - ☐ Regular soft drinks
   - ☐ Diet soft drinks
   - ☐ Fruit-flavored drinks
   - ☐ Sports drinks
   - ☐ Energy drinks
   - ☐ Recovery drinks
   - ☐ Fat-free (skim) milk
   - ☐ Low-fat (1%) milk
   - ☐ Reduced-fat (2%) milk
   - ☐ Whole milk
   - ☐ Flavored milk (for example, chocolate, strawberry)
   - ☐ Coffe or tea
   - ☐ Beer, wine, or hard liquor

10. Which of these foods did you eat last week? *(Check all that apply.)*

Grains
- ☐ Bagels
- ☐ Bread
- ☐ Cereal or grits
- ☐ Crackers
- ☐ Muffins
- ☐ Noodles, pasta, or rice
- ☐ Rolls
- ☐ Tortillas
- ☐ Other grains: ______________________

Vegetables
- ☐ Broccoli
- ☐ Carrots
- ☐ Corn
- ☐ Green beans
- ☐ Green salad
- ☐ Greens (collard, spinach)
- ☐ Peas
- ☐ Potatoes
- ☐ Tomatoes
- ☐ Other vegetables: __________________

Fruits

- ☐ Apples or apple juice
- ☐ Bananas
- ☐ Grapefruits or grapefruit juice
- ☐ Grapes or grape juice
- ☐ Melon
- ☐ Oranges or orange juice
- ☐ Peaches
- ☐ Pears
- ☐ Other fruits or other fruit juice: ______________________

Milk and Milk Products

- ☐ Fat-free (skim) milk
- ☐ Low-fat (1%) milk
- ☐ Reduced-fat (2%) milk
- ☐ Whole milk
- ☐ Flavored milk
- ☐ Cheese
- ☐ Ice-cream
- ☐ Yogurt
- ☐ Other milk and milk products: ________________________

Meat and Meat Alternatives

- ☐ Beef or hamburger
- ☐ Chicken
- ☐ Cold cuts/deli meats
- ☐ Dried beans (for example, black beans, kidney beans, pinto beans)
- ☐ Eggs
- ☐ Fish
- ☐ Peanut butter or nuts
- ☐ Pork
- ☐ Sausage or bacon
- ☐ Tofu
- ☐ Turkey
- ☐ Other meat and meat alternatives: ___________________

Fats and Sweets

- ☐ Cake or cupcakes
- ☐ Candy
- ☐ Chips
- ☐ French fries
- ☐ Cookies
- ☐ Doughnuts
- ☐ Fruit-flavored drinks
- ☐ Pie
- ☐ Soft drinks
- ☐ Other fats and sweets: ___________________

11. Do you have a working stove, oven and refrigerator where you live?

☐ Yes ☐ No

12. Were there any days last month when your family didn't have enough food to eat or enough money to buy food?

☐ Yes ☐ No

13. Are you concerned about your weight?

☐ Yes ☐ No

14. Are you on a diet now to lose weight or to maintain your weight?

☐ Yes ☐ No

15. In the past year, have you tried to lose weight or control your weight by vomiting, taking diet pills or laxatives, or not eating?

☐ Yes ☐ No

16. Did you participate in physical activity (for example, walking or riding a bike) in the past week?

☐ Yes ☐ No

If yes, on how many days and for how many minutes or hours per day? ____________________

17. Do you spend more than 2 hours per day watching television and DVDs or playing computer games?

☐ Yes ☐ No

If yes, how many hours per day? ______________

18. Does the family watch television during meals?

☐ Yes ☐ No

19. Do you take vitamin, mineral, herbal, or other dietary supplements (for example, protein powders)?

☐ Yes ☐ No

20. Do you smoke cigarettes or chew tobacco?

☐ Yes ☐ No

21. Do you ever use any of the following? *(Check all that apply.)*

- ☐ Alcohol, beer, or wine.
- ☐ Steroids (without a doctor's permission)
- ☐ Street drugs (marijuana, speed, crack or heroin)