North Dallas Pediatric Associates

Child's Name _____ **DOB:** _____

Nutrition Questionnaire for Children, Ages 1 - 10

1. How would you describe your child's appetite?
   - ☐ Good
   - ☐ Fair
   - ☐ Poor

2. How many days per week does your family eat meals together? _____

3. How would you describe mealtimes with your child?
   - ☐ Always pleasant
   - ☐ Usually pleasant
   - ☐ Sometimes pleasant
   - ☐ Never pleasant

4. How many meals does your child eat per day? _____
   How many snacks? _____

5. Which of these foods did your child eat or drink last week? *(Check all that apply.)*

Grains
- ☐ Bagels
- ☐ Bread
- ☐ Cereal/grits
- ☐ Crackers
- ☐ Muffins
- ☐ Noodles/pasta/rice
- ☐ Rolls
- ☐ Tortillas
- ☐ Other grains: _____

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

Fruits
- ☐ Apples/juice
- ☐ Bananas
- ☐ Grapefruit/juice
- ☐ Grapes/juice
- ☐ Melon
- ☐ Oranges/juice
- ☐ Peaches
- ☐ Pears
- ☐ Other fruits/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/hamburger
- ☐ Chicken
- ☐ Cold cuts/deli meats
- ☐ Dried beans (for example, black beans, kidney beans, pinto beans)
- ☐ Eggs
- ☐ Fish
- ☐ Peanut butter/nuts
- ☐ Pork
- ☐ Sausage/bacon
- ☐ Tofu
- ☐ Turkey
- ☐ Other meat and meat alternatives: _____

Fats and Sweets

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

6. If your child is 5 years or younger, does he or she eat any of these foods? *(Check all that apply.)*

- ☐ Hot dogs
- ☐ Marshmallows
- ☐ Nuts and seeds
- ☐ Peanut butter
- ☐ Popcorn
- ☐ Pretzels and chips
- ☐ Raisins
- ☐ Raw celery or carrots
- ☐ Hard or chewy candy
- ☐ Whole grapes

7. How much juice does your child drink per day? _____
How much sweetened beverage (for example, fruit punch or soft drinks) does your child drink per day? _____

8. Does your child take a bottle to bed at night or carry a bottle around during the day?

☐ Yes ☐ No

9. What is the source of the water your child drinks? Sources include public, well, commercially bottled, and home system-processed water. _____

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

☐ Yes ☐ No

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

_____
_____
_____

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

☐ Yes ☐ No

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

13. Does your child spend more than 2 hours per day watching television and DVDs or playing computer games?

☐ Yes ☐ No

If yes, how many hours per day? _____

14. Does the family watch television during meals?

☐ Yes ☐ No

15. Does your child take vitamins or other dietary supplements?

16. What concerns or questions do you have about feeding your child or how your child is growing? Do you have any concerns or questions about your child's weight?

_____
_____
_____
_____
_____
_____
_____