What Do You Eat? – Food Frequency Questionnaire
(Ages 8-19)

Circle the names of foods you eat often:

**Iron/Protein**
- Chicken/Turkey
- Beef
- Ham/Pork
- Seafood
- Eggs
- Tofu
- Hot dog
- Hamburger
- Fried Chicken
- Pizza
- Tacos
- Meat/Bean Burrito
- Pasta
- Spaghetti with Meatballs
- Peanut
- Peanut Butter
- Rice
- Noodle Soup
- Beans/Lentils
- Tortilla
- White Bread
- Whole Grain Bread
- Cereal
- Sweet Bread
- Potato
- Dark Green Leafy Vegetables

**Fruits and Vegetables**
- Apple
- Banana
- Grapes
- Pear
- Peach
- 100% Juice
- Strawberry
- Pineapple
- Orange
- Cantaloupe
- Melon
- Bell pepper
- Chili pepper
- Tomato
- Green Salad
- Cucumber
- Mango
- Broccoli
- Cabbage
- Dark Green Leafy Vegetables
- Carrot
- Peas
- Green Beans
- Corn
- Potato
- Sweet Potato

**Snack**
- Cookies
- Fruit Pie
- Donut
- Candies
- Chocolate
- Chips
- Cheese Puffs
- French Fries
- Mexican Bread
- Popcorn
- Bagels
- Pretzels
- Crackers
- Fruits
- Vegetables

**Drinks**
- Water
- 100% Fruit Juice
- Soda
- Fruit Flavored Soda
- Sports Drinks
- Energy Drinks
- Flavored Drinks
- Coffee
- Coffee Drink
- Tea
- Sweetened Tea
- Herbal Tea
- Beer
- Wine
- Wine Cooler
- Alcoholic Drink

**Calcium**
- Nonfat Milk
- 1 % Lowfat Milk
- 2 % Milk
- Whole Milk
- Lactose Free Milk
- Cheese
- Cottage Cheese
- Yogurt
- Milkshake
- Ice Cream
- Calcium Fortified Soy/Plant Milk
- Calcium Fortified 100% Juice
- Tofu
- Tempeh
- Soy Beans
- Green Leafy Vegetables
- Dried Figs
- Prunes
- Orange
- Almonds
- Almond butter
- Tahini
- Beans
- Corn Tortilla

Name: _____________________  Age: _____  Date of Birth: _______

Wt: _____ lbs  Ht: _____ in  BMI: _____  BMI %ile: _____  Date: ______

Office use only:
Circle to indicate the topics discussed:
- Healthy eating
- Regular meals/snacks
- Importance of breakfast
- Inadequate food supply
- Low fat dairy foods
- High sugar foods
- Other: ___________________________

Iron/Protein
- 2-3 servings daily
- High iron foods
- Plant protein sources such as beans, peas, lentils, nuts, etc.
- Limit high fat foods

Fruits and Vegetables
- 2-4 fruits daily or more
- 3-5 vegetables daily or more
- Vitamin C sources
- Vitamin A sources

Calcium
- 3-4 servings dairy foods/day
- Nonfat or 1 % milk
- Lowfat dairy choices
- Low lactose alternative
- Calcium fortified foods
- Other food sources of calcium

Snacks
- High-sugar snacks
- High-fat snacks
- Fruit/vegetable snacks
- Fast foods

Drinks
- < 8-12 oz/day 100% juice
- 6-8 glasses of water (8 ounces each)/day
- Sweetened drinks
- Alcohol/caffeine

Referred for identified nutrition problem?  Yes  No
If yes, where: ___________________________

Provider initials: ___________________
What Do You Eat? – Youth Nutrition and Activity Assessment
(Ages 8 - 19)

Provide additional information about your food, activity and habits:

Eating Habits
Do you eat or drink the following meals? Circle one answer per meal.

Breakfast Always Usually Occasionally Never
Morning snack Always Usually Occasionally Never
Lunch Always Usually Occasionally Never
Afternoon snack Always Usually Occasionally Never
Dinner Always Usually Occasionally Never
Evening Snack Always Usually Occasionally Never

Exercise/Physical Activity
How many hours a day do you?

Watch TV _____ hours/day
Use a smart phone _____ hours/day
Play video/computer games _____ hours/day
Use the internet _____ hours/day

Do you participate in physical education classes at school? Yes No
Circle all that you participate in:

Walking Running Bicycling Swimming
Dance Yoga Martial Arts Rollerblading
Basketball Softball Soccer Volleyball
Other activities or team sports: _____________________________

How often are you physically active?

_____ times/week _____ minutes/day

Weight/Body Image
Circle one. Are you trying to?

Stay the same Lose weight Gain weight Not concerned
Do you eat less to control your weight? Yes No
Explain: ______________________________________________________

Have you ever made yourself vomit? Yes No
If yes, how often? _________ When was the last time? _________

Do you ever “binge” eat? Yes No
If yes, how often? _________ When was the last time? _________

Circle any of the following that you use:

Diet pills Laxatives
Multivitamins Calcium Iron Vitamin D
Protein powder Nutrition supplements Steroids

What, if any, other products do you use?
Explain: ______________________________________________________

Office use only
Complete assessment below using all information provided:

Eating Habits
Overall diet adequate Yes No
3 meals and snacks Yes No
High iron foods Yes No
Calcium foods Yes No
5 or more fruits/vegetables Yes No
Adequate fluids Yes No

Exercise/Physical Activity
Limits use of TV, phone, internet, video or computer games to ≤ 1-2 hours/day

Goal set: ______________________

Engages in physical activity (60 minutes/day or more) Yes No

Goal set: ______________________

Referral made Yes No
Referred to: ___________________

Weight/Body Image
BMI %ile _______ Date ______________

☐ BMI between 5th and 85th %iles
☐ BMI ≤ 5th %ile
☐ BMI between 85th and 95th %iles
☐ BMI ≥ 95th %ile

Signs of eating disorder Yes No
Counseling given Yes No

Topics: ______________________

Goal set: ______________________

Referral made Yes No
Referred to: ___________________