

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

Provider notes:

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

Over the past two weeks, how many hours of sleep per day has your child had? (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? _____

Provider notes:

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