Diet and Exercise Intake Form

Please try to answer these questions as honestly as possible so that we can be of greatest assistance to you.

All questions should be answered from the perspective of the patient (child/young adult).

1) Are you concerned about your (your child's) weight? If so, what are your weight loss goals?
________________________________________________________________________

2) How many calorie containing drinks do you drink per day (including pop and juice)?
________________________________________________________________________

3) What type of milk do you drink primarily?
________________________________________________________________________

4) How many fast food meals do you eat per week (including pizza)?
________________________________________________________________________

5) Do you have a TV in your room?
________________________________________________________________________

6) How many hours per day do you spend in front of a screen including TV, computer, telephone, ipad etc…?
________________________________________________________________________

7) Do you snore or have sleep apnea?
________________________________________________________________________

8) Do you have trouble staying awake during the day?
________________________________________________________________________

9) What is a typical breakfast for you?
________________________________________________________________________
10) What is a typical lunch for you? ______________________________________________

________________________________________________________________________

11) What is a typical dinner for you? ____________________________________________

________________________________________________________________________

12) Do you have a regular exercise routine? ______________________________________

If so, what is it, how many days per week do you do this activity and how long does each
session last?

________________________________________________________________________

13) What do you feel is the biggest weakness or barrier for you that limits weight loss?

________________________________________________________________________