Healthy Lifestyles Survey

Age: ____________________ Grade in school ______________

Self Reported Race/Ethnicity
- Hispanic
- African-American
- Caucasian/White
- Far-East/Asian
- Pacific-Islander
- Other___________

1. How many people in your immediate family (dad, brother, sister, mother, grandparents) have trouble with being overweight? ______________

2. On an average day, how many **hours per day** do you spend:

<table>
<thead>
<tr>
<th>WEEKDAY</th>
<th>WEEKEND</th>
</tr>
</thead>
<tbody>
<tr>
<td>Watching TV:</td>
<td></td>
</tr>
<tr>
<td>On the computer:</td>
<td></td>
</tr>
<tr>
<td>Playing video games:</td>
<td></td>
</tr>
<tr>
<td>Talking or texting on cell phone:</td>
<td></td>
</tr>
<tr>
<td>Reading books:</td>
<td></td>
</tr>
<tr>
<td>Vigorous physical activity:</td>
<td></td>
</tr>
</tbody>
</table>

   Do you have a TV in your room? Yes No

3. Has your doctor told you that you have any illnesses related to your weight? (ie diabetes, high blood pressure, sleep apnea, etc.) If yes, what are they? __________________________________________________________

4. How many **days per week** do you eat breakfast? (please circle)

   1  2  3  4  5  6  7

5. On average, how many **days per week** do you eat out at:

<table>
<thead>
<tr>
<th>Fast Food</th>
<th>Other restaurant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breakfast:</td>
<td></td>
</tr>
<tr>
<td>Lunch:</td>
<td></td>
</tr>
<tr>
<td>Dinner:</td>
<td></td>
</tr>
</tbody>
</table>
6. How many days a week do you skip a meal (including breakfast)? _________

7. Who prepares meals at home? (Please Circle)
   Self   Mom   Dad   Sibling   Other___________________________

8. How many dinners a week are spent sitting down together as a family? ______
   (How many of those are without TV? ______________________)

9. Who generally does the shopping for food in the household?
   Self   Mom   Dad   Sibling   Other:__________________________

8. How many **days per week** do you engage in activity (for at least 30 minutes)
   that makes you BREATHE HARD, SWEAT, and INCREASE YOUR HEART RATE?
   1  2  3  4  5  6  7

   How many of these days are from participating in PE?________________________

9. How do you get to and from school (ex. Car, Walk, Bike..)?____________________

10. On average, how many servings (cans or 8oz glasses) of the following beverages
do you drink **per day**?
    a. Soda ________________
    c. Juice ______________
    b. Diet Soda____________
    d. Water_______________

11. What is your idea of a healthy lifestyle?_____________________________________

12. On a scale of 1-10 (1 being not important & 10 being very important), how
   important is it to you for your child to have a healthy weight? (Please Circle)
   1-2       3-4       5-6       7-8       9-10

13. On a scale of 1-10 (1 being not confident & 10 being very confident), how
    confident are you that your child can attain a healthy weight and maintain it
    successfully? (Please Circle)
   1-2       3-4       5-6       7-8       9-10

14. What do you think will be most challenging about making changes to the family's
    healthy lifestyle? (Please Circle)
   Limited time   Limited family support   Limits in transportation   Other__________