

Name \_\_\_\_\_

Date \_\_\_\_\_

Date of Birth \_\_\_\_\_

# Family Health Habits Assessment & Plan



## A. WHAT ARE YOUR FAMILY HEALTH HABITS?

Please mark the boxes with answers true for most days.



1. Does your family usually eat more than 4 servings of **FRUITS AND VEGETABLES** each day?

Yes

No



2. Do you limit **SCREEN TIME** (TV, computer, video games, phone) in your family?

Yes

No



3. Does your family spend time every day in **ACTIVE PLAY** (fast breathing, sweating)?

Yes

No



4. Are **SODA** or sugary drinks (fruit juice, sweet tea, sports drinks) available in your home?

Yes

No

5. Are **SNACKS**, like cookies, ice cream, candy or chips available in your home?

Yes

No

6. Does your family usually eat **BREAKFAST**?

Yes

No

7. Do you **EAT MEALS TOGETHER** as a family?

Yes

No

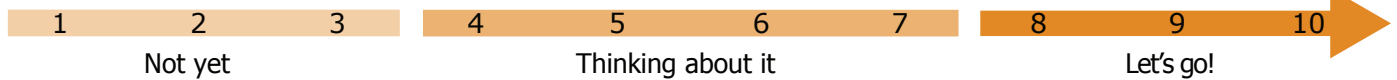
8. Do you keep a **TV** or other **SCREENS** in the rooms where family **SLEEPS**?

Yes

No

## B. ARE YOU READY TO MAKE CHANGES?

Please circle a number.



## C. WHAT WOULD YOU LIKE TO DO?

Please mark one box and write in your goal.



Eat more fruits and vegetables: \_\_\_\_\_ servings daily.



Play (sweat and breathe fast) everyday: \_\_\_\_\_ minutes.



Set limits on screen time: \_\_\_\_\_ hour(s)/daily.



Reduce sugar-sweetened beverage \_\_\_\_\_ servings per week.

Other: \_\_\_\_\_

## D. WHAT MIGHT MAKE IT HARD TO DO THIS?

Please write your answer on the line below.

\_\_\_\_\_

## E. HOW CONFIDENT ARE YOU THAT YOU CAN MAKE CHANGES?

Please circle a number.

