Name _____

Date _____

Date of Birth _____

Family Health Habits Assessment & Plan

five two one almost none

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.

1 2 3 — Not yet

4 5 6 7 — Thinking about it

8 9 10 — Let's go!

C. WHAT WOULD YOU LIKE TO DO?

Please mark one box and write in your goal.

☐ Eat more fruits and vegetables: _____ servings daily.

☐ Set limits on screen time: _____ hour(s)/daily.

☐ Play (sweat and breathe fast) everyday: _____ minutes.

☐ 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.

1 2 3 — Not confident

4 5 6 7 — Somewhat confident

8 9 10 — Very confident

Adapted by WNC Healthy Kids and WNC Pediatric Care Collaborative from NICHQ, The Nemours Foundation, and Eat Smart Move More NC