Name:_____**DOB**:_____**Date**:_____

Completed by: (parent or child) _____

For each of the following questions, circle the number that matches how much you agree or disagree with the statement.

1. Your body has a certain amount of health, and you really can't do much to change it.

Strongly Agree 1 2 3 4 5 6 Strongly Disagree

2. Your health is something about you that you can't change very much

Strongly Agree 1 2 3 4 5 6 Strongly Disagree

3. You can try to make yourself feel better, but you can't really change your basic health

Strongly Agree 1 2 3 4 5 6 Strongly Disagree

Check what your child normally drinks:

❑ Milk ❑ Water ❑ 100 % juice ❑ Soda ❑ Diet Soda ❑ Sports drinks ❑ Minute Maid punch

❑ Kool Aid ❑ Sugar-free Kool Aid ❑ Crystal Light ❑ Capri Sun ❑ Hi C punch ❑ Strawberry/chocolate milk

❑ Coffee drinks ❑ Sweet tea ❑ Unsweet tea ❑ Energy Drinks (Red Bull, Monster) ❑Smoothies/Frappes

❑ Other drinks? Please list: _____

How many times a day does your child eat vegetables? _____Favorite vegetable:_____

How many times a day does your child eat fruit? _____Favorite fruit:_____

How many times a week does your child eat fast food? _____

What does your child do for exercise? (PE, sports, dance, etc.) _____

How often does your child exercise and for how long? _____

Screen time not for school: (computer, TV, video games, etc.) _____**hours/day**

What time does your child go to sleep? _____**wake up?**_____**Total hours of sleep:**_____

9 ☐ **5** ☐ **2** ☐ **1** ☐ **0** ☐