What Do You Eat? – Food Frequency Questionnaire

(Ages 8-19)

Circle the names of foods you eat often:

**Iron/Protein**
- Chicken/Turkey
- Beef
- Ham/Pork
- Seafood
- Eggs
- Tofu
- Hot dog
- Hamburger
- Fried Chicken
- Pizza
- Tacos
- Meat/Bean Burrito
- Pasta
- Spaghetti with Meatballs
- Peanut
- Peanut Butter
- Rice
- Noodle Soup
- Beans/Lentils
- Tortilla
- White Bread
- Whole Grain Bread
- Cereal
- Sweet Bread
- Potato
- Dark Green Leafy Vegetables

**Fruits and Vegetables**
- Apple
- Banana
- Grapes
- Pear
- Peach
- 100% Juice
- Strawberry
- Pineapple
- Orange
- Cantaloupe
- Melon
- Bell pepper
- Chili pepper
- Tomato
- Green Salad
- Cucumber
- Mango
- Broccoli
- Cabbage
- Dark Green Leafy Vegetables
- Carrot
- Peas
- Green Beans
- Corn
- Potato
- Sweet Potato

**Snack**
- Cookies
- Fruit Pie
- Donut
- Candies
- Chocolate
- Chips
- Cheese Puffs
- French Fries
- Mexican Bread
- Popcorn
- Bagels
- Pretzels
- Crackers
- Fruits
- Vegetables

**Drinks**
- Water
- 100% Fruit Juice
- Soda
- Fruit Flavored Soda
- Sports Drinks
- Energy Drinks
- Flavored Drinks
- Coffee
- Coffee Drink
- Tea
- Sweetened Tea
- Herbal Tea
- Beer
- Wine
- Wine Cooler
- Alcoholic Drink

**Calcium**
- Nonfat Milk
- 1 % Lowfat Milk
- 2 % Milk
- Whole Milk
- Lactose Free Milk
- Cheese
- Cottage Cheese
- Yogurt
- Milkshake
- Ice Cream
- Calcium Fortified Soy/Plant Milk
- Calcium Fortified 100% Juice
- Tofu
- Tempeh
- Soy Beans
- Green Leafy Vegetables
- Dried Figs
- Prunes
- Orange
- Almonds
- Almond butter
- Tahini
- Beans
- Corn
- Tortilla

Name: _____________________ Age: ____ Date of Birth: __________

Wt: _____ lbs Ht: _____ in BMI: _____ BMI %ile: _____ Date: ______

Office use only:
Circle to indicate the topics discussed:
- Healthy eating
- Regular meals/snacks
- Importance of breakfast
- Inadequate food supply
- Low fat dairy foods
- High sugar foods
- Other: ___________________________

**Iron/Protein**
- 2-3 servings daily
- High iron foods
- Plant protein sources such as beans, peas, lentils, nuts, etc.
- Limit high fat foods

**Fruits and Vegetables**
- 2-4 fruits daily or more
- 3-5 vegetables daily or more
- Vitamin C sources
- Vitamin A sources

**Calcium**
- 3-4 servings dairy foods/day
- Nonfat or 1 % milk
- Lowfat dairy choices
- Low lactose alternative
- Calcium fortified foods
- Other food sources of calcium

**Snacks**
- High-sugar snacks
- High-fat snacks
- Fruit/vegetable snacks
- Fast foods

**Drinks**
- < 8-12 oz/day 100% juice
- 6-8 glasses of water (8 ounces each)/day
- Sweetened drinks
- Alcohol/caffeine

Referred for identified nutrition problem?  Yes  No
If yes, where: ______________________
Provider initials: ____________________
Provide additional information about your food, activity and habits:

Eating Habits
Do you eat or drink the following meals? Circle one answer per meal.
- Breakfast: Always Usually Occasionally Never
- Morning snack: Always Usually Occasionally Never
- Lunch: Always Usually Occasionally Never
- Afternoon snack: Always Usually Occasionally Never
- Dinner: Always Usually Occasionally Never
- Evening Snack: Always Usually Occasionally Never

Exercise/Physical Activity
How many hours a day do you?
- Watch TV: _______ hours/day
- Use a smart phone: _______ hours/day
- Play video/computer games: _______ hours/day
- Use the internet: _______ hours/day
Do you participate in physical education classes at school? Yes No
Circle all that you participate in:
- Walking
- Running
- Bicycling
- Swimming
- Dance
- Yoga
- Martial Arts
- Rollerblading
- Basketball
- Softball
- Soccer
- Volleyball
Other activities or team sports: _____________________________
How often are you physically active?
_____ times/week  _____ minutes/day

Weight/Body Image
Circle one. Are you trying to?
Stay the same  Lose weight  Gain weight  Not concerned
Do you eat less to control your weight? Yes No
Explain: ____________________________________________
Have you ever made yourself vomit? Yes No
If yes, how often? When was the last time? __________
Do you ever “binge” eat? Yes No
If yes, how often? When was the last time? __________
Circle any of the following that you use:
- Diet pills
- Laxatives
- Multivitamins
- Calcium
- Iron
- Vitamin D
- Protein powder
- Nutrition supplements
- Steroids
What, if any, other products do you use?
Explain: ____________________________________________

Office use only
Complete assessment below using all information provided:

Eating Habits
Overall diet adequate Yes No
3 meals and snacks Yes No
High iron foods Yes No
Calcium foods Yes No
5 or more fruits/vegetables Yes No
Adequate fluids Yes No

Exercise/Physical Activity
Limits use of TV, phone, internet, video or computer games to ≤ 1-2 hours/day Yes No
Goal set: ______________________
Engages in physical activity (60 minutes/day or more) Yes No
Goal set: ______________________
Referral made Yes No
Referred to: _____________________

Weight/Body Image
BMI %ile ________  Date ____________
- BMI between 5th and 85th %iles
- BMI ≥ 5th %ile
- BMI between 85th and 95th %iles
- BMI ≥ 95th %ile
Signs of eating disorder Yes No
Counseling given Yes No
Topics: ____________________________
Goal set: ______________________
Referral made Yes No
Referred to: _____________________