Patient Name:_____ DOB:_____

Pediatrics Wellness Questions

Nutritional Assessment:

1.) Is the patient's current diet nutritious and satisfying?

a. **Yes** b. **No**

2.) How many servings of vegetables and fruits does the patient have a day?

a. **None** b. **1 serving** c. **2 servings** c. **3 servings** d. **4 servings** e. **5 servings**

f. **More than 5 servings a day**

3.) How many servings of water does the patient have a day?

a. **None** b. **1 serving** c. **2 servings** d. **3 servings** d. **4 servings**

e. **More than 4 servings**

4.) How many servings of dairy does the patient have a day?

a. **None** b. **1 serving** c. **2 servings** d. **3 servings** d. **More than 3 servings**

Physical Activity Assessment:

1.) Circle the follow activities that would apply to the patient's physical activity:

a. **Walking** b. **Running** c. **Jumping** **d. Swimming** e. **Biking**

f. **Sports** e. **Playing**

2.) For how long is the patient physically active?

a. **Less than 30 minutes** b. **Less than 1 hour** **c. More than 1 hour**

3.) How often is the patient physically active?

a. **1 day per week** b. **2 days per week** c. **3 days per week** d. **4 days per week**

e. **5 days per week** f. **6 days per week** g. **Daily**

4.) Are there any smokers in the house?

a. **Yes** b. **No**

Screen Time Assessment:

1.) How many hours does the patient spend in front of a television, computer, Ipad, Iphone, and/or video games?

a. **1 hour** b. **2 hours** c. **3 hours** d. **4 hours** e. **5 hours** f. **6 hours**

g. **7 hours** h. **8 hours** i. **More than 8 hours a day**