bright&early
CHILDREN'S LEARNING CENTERS

FAMILY NUTRITION QUESTIONNAIRE

1. How would you describe your child's appetite? (Check one.)
   Good Fair Poor Picky

2. How many days per week does your family usually eat meals together? _____

3. How would you describe mealtimes with your child? (Check one.)
   Always pleasant Usually pleasant Sometimes pleasant Never pleasant

4. How many meals does your child usually eat per day? _____

5. How many snacks does your child usually eat per day? _____

6. Which of these foods did your child eat or drink last week? (Check all that apply.)

	Grains		**Vegetables**		**Fruits**
	Bagels		Broccoli		Apples/juice
	Bread		Carrots		Bananas
	Cereal/grits		Corn		Berries
	Crackers		French fries		Grapefruit/juice
	Muffins		Green beans		Grapes/juice
	Noodles/pasta		Green salad		Melon
	Rice		Greens (collard,spinach)		Oranges/juice
	Rolls		Peas		Peaches
	Tortillas		Potatoes		Pears
	Other grains:		Tomatoes		Other fruits/juice:
			Other vegetables:		

	Milk and Other Dairy		**Meat/Meat Alternates**		**Fats and Sweets**
	Whole milk		Beef/hamburger		Cake/cupcakes
	2% milk (reduced-fat)		Chicken		Candy
	1% milk (low-fat)		Cold cuts/lunch meat		Chips
	Skim milk		Dried beans		Cookies
	Chocolate milk		Eggs		Doughnuts
	Cheese		Fish		Fruit-flavored drinks
	Ice cream		Peanut butter/nuts		Kool-Aid®
	Yogurt		Pork		Pie
	Other milk and dairy:		Sausage/bacon		Soft drinks
			Tofu		Other fats and sweets:
			Turkey		
			Other meat/alternates:		

FAMILY NUTRITION QUESTIONNAIRE (continued)

7. If your child is 5 years of age or younger; does he or she eat any of these foods? (Check all that apply.)

Hot dogs	Popcorn	Raw celery or carrots
Marshmallows	Pretzels and chips	Round or hard candy
Nuts and seeds	Raisins	Whole grapes
Peanut butter		

8. How much 100% juice (for example, orange juice, apple juice and grape juice) does your child drink per day? _____

9. How much sweetened beverage (for example, Kool-Aid®, fruit punch and soft drinks) does your child drink per day? _____

10. Does your child drink water that is fluoridated or take a fluoride supplement?
    Yes No Don't know

11. Does your child take a bottle to bed at night or carry a bottle or sippy cup around during the day?
    □ Yes No

12. Do you have a working stove, oven and refrigerator where you live?
    □ Yes No

13. Were there any days last month when your family didn't have enough food to eat or enough money to buy food?
    □ Yes No

14. Does your child spend more that 2 hours per day watching television and videotapes or playing computer games?
    □ Yes No

15. What concerns or questions do you have about feeding your child?
    _____
    _____
    _____

Date_____

Student _____