Nutrition Questionnaire for Infants

1. How would you describe feeding time with your baby? *(Check all that apply.)*
   - ☐ Always pleasant
   - ☐ Usually pleasant
   - ☐ Sometimes pleasant
   - ☐ Never pleasant
2. How do you know when your baby is hungry or has had enough to eat?
3. What type of milk do you feed your baby? *(Check all that apply.)*
   - ☐ Breastmilk
   - ☐ Iron-fortified infant formula
   - ☐ Low-iron infant formula
   - ☐ Goat's milk
   - ☐ Evaporated milk
   - ☐ Whole milk
   - ☐ Reduced-fat (2%) milk
   - ☐ Low-fat (1%) milk
   - ☐ Fat-free (skim)
4. What types of things can your baby do? *(Check all that apply.)*
   - ☐ Open mouth for breast or bottle
   - ☐ Drink liquids
   - ☐ Follow objects and sounds with eyes
   - ☐ Put hand in mouth
   - ☐ Sit with support
   - ☐ Bring objects to mouth and bite them
   - ☐ Hold bottle without support
   - ☐ Drink from a cup that is held
5. Does your baby eat solid foods? If so, which ones?
6. Does your baby drink juice? If so, how much?
7. Does your baby take a bottle to bed at night or carry a bottle around during the day?
8. Do you add honey to your baby's bottle or dip your baby's pacifier in honey?
9. What is the source of the water your baby drinks? Sources include public, well, commercially bottled, and home system–processed water.
10. Do you have a working stove, oven, and refrigerator where you live?
11. Were there any days last month when your family didn't have enough food to eat or enough money to buy food?
12. What concerns or questions do you have about feeding your baby?

Nutrition Questionnaire for Children

1. How would you describe your child's appetite?
   - ☐ Good
   - ☐ Fair
   - ☐ Poor
2. How many days does your family eat meals together per week?
3. How would you describe mealtimes with your child?
   - ☐ Always pleasant
   - ☐ Usually pleasant
   - ☐ Sometimes pleasant
   - ☐ Never pleasant
4. How many meals does your child eat per day? How many snacks?
5. Which of these foods did your child eat or drink last week? *(Check all that apply.)*

Grains

☐ Bread ☐ Noodles/pasta/rice
☐ Rolls ☐ Tortillas
☐ Bagels ☐ Crackers
☐ Muffins ☐ Cereal/grits
☐ Other grains: ______________________________
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Vegetables

☐ Corn ☐ Greens (collard, spinach)
☐ Peas ☐ Green salad
☐ Potatoes ☐ Broccoli
☐ French fries ☐ Green beans
☐ Tomatoes ☐ Carrots
☐ Other vegetables: ___________________________
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Fruits

☐ Apples/juice ☐ Bananas
☐ Oranges/juice ☐ Pears
☐ Grapefruit/juice ☐ Melon
☐ Grapes/juice ☐ Peaches
☐ Other fruits/juice: __________________________
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Milk and Other Dairy Products

☐ Whole milk ☐ Yogurt
☐ Reduced-fat (2%) milk ☐ Cheese
☐ Low-fat (1%) milk ☐ Ice cream
☐ Fat-free (skim) milk ☐ Flavored milk
☐ Other milk and dairy products: ______________
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Meat and Meat Alternatives

☐ Beef/hamburger ☐ Sausage/bacon
☐ Pork ☐ Peanut butter/nuts
☐ Chicken ☐ Eggs
☐ Turkey ☐ Dried beans
☐ Fish ☐ Tofu
☐ Cold cuts
☐ Other meat and meat alternatives: ___________
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Fats and Sweets

☐ Cake/cupcakes ☐ Doughnuts
☐ Pie ☐ Candy
☐ Cookies ☐ Fruit-flavored drinks
☐ Chips ☐ Soft drinks
☐ Other fats and sweets: _______________________
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6. If your child is 5 years old or younger, does he or she eat any of these foods? *(Check all that apply.)*

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

7. How much juice does your child drink per day? How much sweetened beverage (for example, fruit punch, and soft drinks) does your child drink per day?

8. Does your child take a bottle to bed at night or carry a bottle around during the day?

   ☐ Yes ☐ No

9. What is the source of the water your child drinks? Sources include public, well, commercially bottled, and home system–processed water.

10. Do you have a working stove, oven, and refrigerator where you live?

    ☐ Yes ☐ No

11. Were there any days last month when your family didn't have enough food to eat or enough money to buy food?

12. Did you participate in physical activity (for example, walking or riding a bike) in the past week? If yes, on how many days and for how long?

    ☐ Yes ☐ No

13. Does your child spend more than 2 hours per day watching television and videotapes or playing computer games? If yes, how many hours per day?

    ☐ Yes ☐ No

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

Nutrition Questionnaire for Adolescents

1. Which of these meals or snacks did you eat yesterday? *(Check all that apply.)*

   ☐ Breakfast ☐ Afternoon snack
   ☐ Morning snack ☐ Dinner/supper
   ☐ Lunch ☐ Evening snack

2. Do you skip breakfast three or more times a week?

   ☐ Yes ☐ No

   Do you skip lunch three or more times a week?

   ☐ Yes ☐ No

   Do you skip dinner/supper three or more times a week?

   ☐ Yes ☐ No

3. Do you eat dinner/supper with your family four or more times a week?

   ☐ Yes ☐ No

4. Do you fix or buy the food for any of your family's meals?

   ☐ Yes ☐ No

5. Do you eat or take out a meal from a fast-food restaurant two or more times a week?

   ☐ Yes ☐ No

6. Are you on a special diet for medical reasons?

   ☐ Yes ☐ No

7. Are you a vegetarian?

   ☐ Yes ☐ No

8. Do you have any problems with your appetite, like not feeling hungry, or feeling hungry all the time?

   ☐ Yes ☐ No

9. Which of the following did you drink last week? *(Check all that apply.)*

   ☐ Regular soft drinks ☐ Coffee/tea
   ☐ Diet soft drinks ☐ Tap/bottled water
   ☐ Fruit-flavored drinks ☐ Juice
   ☐ Whole milk ☐ Sports drinks
   ☐ Reduced-fat (2%) milk ☐ Beer/wine/hard liquor
   ☐ Low-fat (1%) milk
   ☐ Fat-free (skim) milk
   ☐ Flavored milk (for example, chocolate, strawberry)

10. Which of these foods did you eat last week? *(Check all that apply.)*

    Grains

    ☐ Bread ☐ Cereal/grits
    ☐ Rolls ☐ Popcorn
    ☐ Bagels ☐ Noodles/pasta/rice
    ☐ Crackers ☐ Tortillas
    ☐ Other grains: ______________________________
    ____

    Vegetables

    ☐ Corn ☐ Greens (collard, spinach)
    ☐ Peas ☐ Green salad
    ☐ Potatoes ☐ Broccoli
    ☐ French fries ☐ Green beans
    ☐ Tomatoes ☐ Carrots
    ☐ Other vegetables: ___________________________
    ____

Fruits

- ☐ Apples/juice
- ☐ Peaches
- ☐ Oranges/juice
- ☐ Pears
- ☐ Grapefruit/juice
- ☐ Berries
- ☐ Grapes/juice
- ☐ Melon
- ☐ Bananas
- ☐ Other fruits/juice: ________________________

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Milk and Other Dairy Products

- ☐ Whole milk
- ☐ Yogurt
- ☐ Reduced-fat (2%) milk
- ☐ Cheese
- ☐ Low-fat (1%) milk
- ☐ Ice cream
- ☐ Fat-free (skim) milk
- ☐ Flavored milk
- ☐ Other milk and dairy products: ____________

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Meat and Meat Alternatives

- ☐ Beef/hamburger
- ☐ Sausage/bacon
- ☐ Pork
- ☐ Peanut butter/nuts
- ☐ Chicken
- ☐ Eggs
- ☐ Turkey
- ☐ Dried beans
- ☐ Fish
- ☐ Tofu
- ☐ Cold cuts
- ☐ Other meat and meat alternatives: _________

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Fats and Sweets

- ☐ Cake/cupcakes
- ☐ Chips
- ☐ Pie
- ☐ Doughnuts
- ☐ Cookies
- ☐ Candy
- ☐ Other fats and sweets: ____________________

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11. Do you have a working stove, oven, and refrigerator where you live?

    ☐ Yes ☐ No

12. Were there any days last month when your family didn't have enough food to eat or enough money to buy food?

    ☐ Yes ☐ No

13. Are you concerned about your weight?

    ☐ Yes ☐ No

14. Are you on a diet now to lose weight or to maintain your weight?

    ☐ Yes ☐ No

15. In the past year, have you tried to lose weight or control your weight by vomiting, taking diet pills or laxatives, or not eating?

    ☐ Yes ☐ No

16. Did you participate in physical activity (for example, walking or riding a bike) in the past week? If yes, on how many days and for how long?

    ☐ Yes ☐ No

17. Do you spend more than 2 hours per day watching television and videotapes or playing computer games? If yes, how many hours per day?

    ☐ Yes ☐ No

18. Do you take vitamin, mineral, herbal, or other dietary supplements (for example, protein powders)?

    ☐ Yes ☐ No

19. Do you smoke cigarettes or chew tobacco?

    ☐ Yes ☐ No

20. Do you ever use any of the following? *(Check all that apply.)*

    - ☐ Alcohol/beer/wine
    - ☐ Steroids (without a doctor's permission)
    - ☐ Street drugs (marijuana/speed/crack/heroin)