# My Healthy Living Plan

Name _____ EHR#_____ Date_____

I – refers to child if parent completing survey for child

## What am I doing now?

**Nutrition & Diet**

How many times a day do I eat **fruits or vegetables**? _____

How many times a day do I drink **sugar sweetened beverages?** (juice, soda, ice tea, Kool-Aid, sports drink)_____

How many times a day do I eat **junk food**? (*cake, cookies, chips etc.*) _____

How many times a week do I eat **takeout or fast food**? _____

**Exercise & Physical Activity**

On most days, how many minutes do I spend in **active play or exercise**? (fast breathing, sweating) _____

How many hours a day do I watch **TV/movies** or sit and play **video games** or use **the cell phone** or **the computer** for fun? _____

**Other habits**

How many times *a week* do I **skip meals**? _____

How many days a week do I have trouble **sleeping?** _____

How many times *a week* do I **eat dinner at the table with my family**?_____

Do I have a **TV in the room** where I sleep? Yes_____ No_____

## I will try at least one goal. No more than 3 goals.

☐ Increase the fruits or vegetables I eat each day to: (Check one below)
___5 ___4 ___3 ___2 ___1

☐ Decrease screen time (TV/movie, video games, cell phone, computer, etc.) to: (Check one below)
___ 2 hours ___ 2 ½ hours ___ 3 hours ___3 ½ hours ___ 4 hours

☐ Increase exercise or physical activity every day to: (Check one below)
___1 hour ___45 minutes ___30 minutes ___15 minutes

☐ Decrease sugar-sweetened drinks (soda, sports drinks, juice, punch, etc.) to: (Check one below)
___ 0 per day ___ 1 per day ___ 2 per day

☐ Another goal_____

## How confident am I to accomplish my goal?

*Not confident* *Very confident*

0 1 2 3 4 5 6 7 8 9 10

What might make it hard to achieve this goal (What are my barriers)?

_____