

My Healthy Living Plan

Date: _____



<input type="checkbox"/> Enter the first letter of your first name <input type="checkbox"/> Enter the first letter of your mother's first name <input type="checkbox"/> Enter the first letter of your last name	Enter your birthday: M M D D Y Y Y Y <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> / <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <i>Example: 07/29/1985</i>	Select your gender: <input type="radio"/> Male <input type="radio"/> Female
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About Let's Move Holyoke 5210

Please select the amount that matches the 5-2-1-0 recommendations.

1. Screen time per day (TV/movies, video games, or use the cell phone or the computer for fun)
 5 hours or less 2 hours or less 1 hour or less 0 hours
2. Fruits and vegetables per day
 5 servings 2 servings 1 serving 0 servings
3. Sugar-sweetened beverages per day (soda, sports drinks, juice, punch, ice tea, Kool-Aid, etc.)
 5 servings 2 servings 1 serving 0 servings
4. Exercise or active play per day
 5 hours or more 2 hours or more 1 hour or more 0 hours

Progress on Goal- Complete ONLY if you have done a Healthy Living Plan before

The last time I filled out this survey I set a goal Yes No I don't remember

If YES, thinking about last week, I accomplished my goal(s):

- 7 days a week 5 or 6 days a week 3 or 4 days a week 1 or 2 days a week 0 days a week

Please turn over to complete back page.

Date: _____
Location: <input type="checkbox"/> YMCA <input type="checkbox"/> Head Start <input type="checkbox"/> HHC Healthy Weight Clinic <input type="checkbox"/> School <input type="checkbox"/> WIC <input type="checkbox"/> Other _____
Program or site name: _____
Survey administration: <input type="checkbox"/> Pre-Survey <input type="checkbox"/> Post-Survey
Post-Survey Only:
Type of interaction with program: <input type="checkbox"/> Single encounter <input type="checkbox"/> Multiple encounter
Number of contact hours: <input type="checkbox"/> Up to 1 hour <input type="checkbox"/> 1-3 hours <input type="checkbox"/> 4-6 hours <input type="checkbox"/> 7-9 hours <input type="checkbox"/> 10 or more hours

My Healthy Living Plan



What am I doing now?
child

I- refers to child if parent is completing the survey for

Nutrition

How many fruits did I eat yesterday? _____

How many vegetables did I eat yesterday? _____

How many sugar-sweetened beverages (*juice, soda, ice tea, Kool-Aid, sports drink*) did I drink yesterday? _____

How many times did I eat junk food (*cake, cookies, chips, etc.*) yesterday? _____

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

Exercise and Physical Activity

How many days a week do I spend in active play or exercise (*fast breathing, sweating*)?
_____ days

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

What activities?

How many hours did I watch TV/movies or sit and play video games or use the cell phone or the computer for fun yesterday? _____

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.**

Please choose no more than 3 goals

- **5** Increase the fruits or vegetables I eat each day to: (*Check one below*)
_____5 _____4 _____3 _____2 _____1



- **2** Decrease screen time (*TV/movies, video games, cell phones, computer etc.*) to:
(*Check one below*)

_____2 hours _____2 ½ hours _____3 hours _____3 ½ hours _____4 hours



- **1** Increase exercise or physical activity every day to: (*Check one below*)

_____1 hour _____45 minutes _____30 minutes _____15 minutes _____Other



- **0** Decrease sugar-sweetened drinks (*soda, sports drinks, juice, punch, etc.*) to: (*Check one below*)

_____0 per day _____1 per day _____2 per day

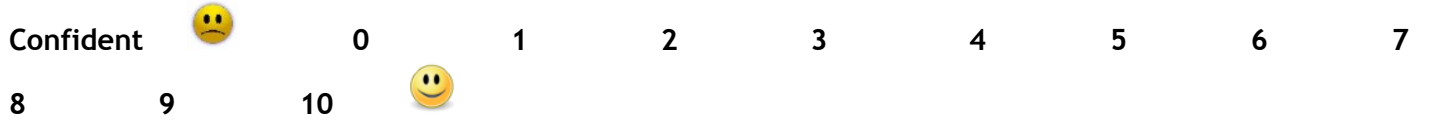


- **Another goal:**

How confident am I to accomplish my goal?

Not Confident

Very



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