Morelife
The power to be more you

# Healthy Behaviours Questionnaire

Your Name..... Date.....

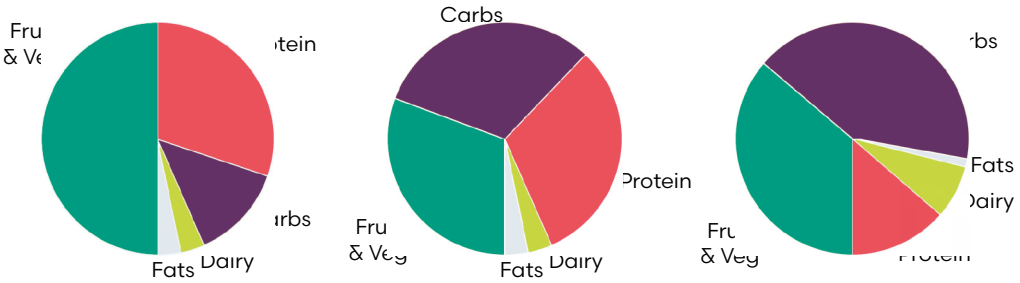
Child's Name.....

## NUTRITION

1. Do you think your child knows what a balanced diet is?

Yes No

2. Tick the circle that you think looks like a balanced diet.




Why have you chosen this one?.....

3. Do you use the food traffic light system at home?

Yes Sometimes No

4. It is recommended to have three meals a day. In the past seven days, on how many of those days did you have three meals?

1 2 3 4 5 6 7

5. **Does your family enjoy eating a range of different fruits and vegetables?**

Yes No Some fruits and vegetables

6. What is it about fruits and vegetables that your family doesn't like?

Taste Texture Smell Way they look

Other.....

7. Does your child/children enjoy trying new foods?

Yes Sometimes No

8. Are you aware of the sugar content within different drink options?

Yes No

9. How much sugar do you think your child/children should be having each day?

1tsp 2tsp 3tsp 4tsp 5tsp 6tsp

10. Using the hunger fullness 10-point scale. A score of 1 means you are not hungry at all, such as after eating a large meal. A score of 10 is when you are extremely hungry, such as after you have missed a meal.

What number would you give out of 10 to show how you feel after a good meal?

1 2 3 4 5 6 7 8 9 10

11. Do you usually try to eat all of the food on your plate, even if you feel full?

Yes No

12. Have you noticed your child restricting their diet in any way?

Yes No

13. Do you and your family have regular meal patterns e.g. breakfast at 7:30 am, lunch at 1 pm, and dinner at 6:30 pm?

Yes Sometimes No

14. Do you eat dinner together as a family?

Yes No

15. If you answered yes, where is this meal eaten? If you answered no, why don't you?

.....

## SCREEN TIME

1. Do you limit your child's/children's screen time?

Yes Sometimes No

2. Do you find it hard trying to limit your child's/children's screen time?

Yes No

If yes, then why is this? .....

## SLEEP

1. Do you think you and your family get an adequate amount of sleep?

Yes No

If no, why do you think this is? .....

2. How do you feel when you wake up each morning?

Full of Energy Normal Sleepy/Tired

## GENERAL

1. We are looking at how best to collect feedback from our clients, would you have been happy to complete this survey online?

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