For office use only:
Child ID _____ __ **Child's Initials** __ __ __

MAYO CLINIC FAMILY DEMOGRAPHIC SURVEY

Please enter today's date: __ __ / __ __ / __ __ __ __ (mm/dd/yyyy)

Please mark an "X" in the box next to your answer. If you feel uncomfortable with answering a particular question, feel free to leave it blank.

Caregiver completing form: ☐ Mother ☐ Father ☐ Other (please write) _____

Your Age: _____ years

Your Marital Status: ☐ Single ☐ Divorced ☐ Live with a partner
☐ Married ☐ Separated ☐ Widowed

Your Race/Ethnicity: ☐ American Indian ☐ Black/African America ☐ Hispanic/Latino
(mark all that apply) ☐ Asian ☐ Caucasian ☐ Multi-ethnicity
☐ Other (please write) _____

Your Education: ☐ Less than High School Diploma ☐ High School Diploma or GED
(Mark highest level) ☐ Some College or Vocational Training ☐ College degree - 2 years
☐ College degree - 4 years ☐ Post-Baccalaureate Education/Degree

Your Employment: ☐ Full time ☐ Part time ☐ Not employed outside of home

Contact Information: (This will only be used by study team to obtain follow-up study information)

Your Name: Mr. ☐ Mrs. ☐ Ms. ☐ (First) _____ (Last) _____

Your Email Address: _____

Your Phone Number: Cell: ( ) _____- _____ Home: ( ) _____- _____

Your Home address: (Street or P.O. Box) _____

(City, State & ZIP Code) _____

Child's Race/Ethnicity: ☐ American Indian ☐ Black/African American ☐ Hispanic/Latino
(mark all that apply) ☐ Asian ☐ Caucasian ☐ Multi-ethnicity
☐ Other (please write) _____

Child's Date of Birth: __ __ / __ __ / __ __ __ __ (mm/dd/yyyy) **Child's Gender**: ☐ Female ☐ Male

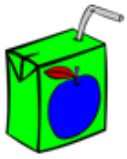
For office use only: Survey date: ____-____-_____
Visit: ___Initial ___6 month ___12 month
Child ID _____ Child's Initials _____

Ways I Can Stay Healthy

Directions: For each question below, **circle one answer** from the number choices.

1. **How many**  **fruits** **and**  **vegetables** **should I eat each day?**

Circle one answer: **At least: 0 1 2 3 4 5** (servings)

2. **How much**  **Pop/Soda** **or**  **Juice (sugary drinks)** **or**  **Kool-Aid** **can I have each day?**

Circle one answer: **0 1 2 3 4 5** (cups)

3. **How much**  **Sleep** **should I get each night?**

Circle one answer: **At least: 7 8 9 10 11 12** (hours)

For office use only: Survey date: ____-____-_____

Visit: ___ Initial ___ 6 month ___ 12 month

Child ID _____ Child's Initials _____

(Survey continued)

4. How much Exercise should I get each day?

Circle one answer: **At least: 0 1 2 3 4 5** (hours)

5. How much time can I spend on a  **Computer or**  **TV (screen time) or**  **iphone each day?**

Circle one answer: **No more than: 0 1 2 3 4 5** (hours)

Thank you!

For office use only:

Child ID __ __ __ Child's Initials __ __ __

Modified 5-2-1-0 Healthy Habits Questionnaire

Please enter today's date __ __ / __ __ / __ __ __ __

We are interested in the health and well-being of your child. Please take a moment to answer the following questions. **Circle <u>ONLY one answer</u> for each question**.

1. How many servings of fruits or vegetables does your child eat a day?
   One serving is most easily identified by the size of the palm of your child's hand.

   0 1 2 3 4 5 or more

2. How many times a week does your child eat dinner at the table together with the family?

   0 1 2 3 4 5 6 7 or more

3. How many times a week does your child eat breakfast?

   0 1 2 3 4 5 6 7

4. How many times a week does your child eat takeout or fast food?

   0 1 2 3 4 5 6 7 or more

5. How many 8-ounce (1 cup) servings of the following does your child drink a day?

100% Juice	0	1	2	3	4	5 or more
Fruit drinks or sports drinks	0	1	2	3	4	5 or more
Soda or punch	0	1	2	3	4	5 or more
Water	0	1	2	3	4	5 or more
Whole milk	0	1	2	3	4	5 or more
Nonfat or reduced fat milk	0	1	2	3	4	5 or more

6. How many hours a day does your child watch TV/movies or sit and play Video/computer games?

   0-2 3-4 5-6 7 or more

For office use only:

Child ID _____ __ Child's Initial's __ __ __

Today's date: __ __/ __ __/ __ __ __ __

Modified 5-2-1-0 Healthy Habits Questionnaire continued…

7. How much time a day does your child spend in active play (faster breathing/heart rate or sweating)?

None 15 minutes 30 minutes 1 hour 90 minutes 2 hours or more

8. How many hours of sleep does your child get each night?

Less than 4 hours 5 6 7 8 9 10 or more

9. Does your child have a TV in the room where he /she sleeps?
Yes No

10. Does your child have a computer in the room where he /she sleeps?
Yes No

11. Based on your answers, is there ONE thing you would like to help your child change now?
Please check ONLY one.

_ Eat more fruits & vegetables.

_ Spend less time watching TV/movies and playing video/computer games.

_ Take the TV out of the bedroom.

_ Eat less fast food/ takeout.

_ Play outside more often.

_ Drink less soda, juice, or punch.

_ Switch to skim or low fat milk.

_ Drink more water.

_ Other_____