

## NUTRITION QUESTIONNAIRE FOR ADOLESCENTS AGES 11 TO 21

1. Which of these meals or snacks did you eat yesterday?  
(Check all that apply)
- Breakfast
  - Lunch
  - Dinner or supper
  - Morning snack
  - Afternoon Snack
  - Evening/late-snack
2. Do you skip breakfast 3 or more times a week?  
 Yes             No
- Do you skip lunch 3 or more times a week?  
 Yes             No
- Do you skip dinner or supper 3 or more times a week?  
 Yes             No
3. Do you eat dinner or supper with your family 4 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 2 or more times a week?  
 Yes             No
6. Are you on 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)
- Tap or bottled water
  - Fitness water
  - Juice
  - Regular soft drinks
  - Diet soft drinks
  - Fruit-flavored drinks
  - Sport drinks
  - Energy drinks
  - Recovery drinks
  - Fat-free (skim) milk
  - Low-fat (1%) milk
  - Reduced-fat (2%) milk
  - Whole milk
  - Flavored milk (for example, chocolate, strawberry)
  - Coffee or tea
  - Beer, wine, or hard liquor
10. Which of these foods did you eat last week?  
(Check all that apply)
- Grains:**
- Bagels
  - Bread
  - Cereal/grits
  - Crackers
  - Muffins
  - Noodles/pasta/rice
  - Rolls
  - Tortillas
  - Other grains:.....
- Vegetables**
- Broccoli
  - Carrots
  - Corn
  - Green beans
  - Green salad
  - Greens (collard, spinach)
  - Peas
  - Potatoes
  - Tomatoes
  - Other vegetables.....
- Fruits**
- Apples/ juice
  - Bananas
  - Grapefruit/juice
  - Grapes/juice

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- Melon
- Oranges/juice
- Peaches
- Pears
- Other fruits/juice:.....

### Milk and Milk Products

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

### Meal and Meal Alternatives

- Beef/hamburger
- Chicken
- Cold cuts/deli meals
- Dried beans (for example, black beans, kidney beans, pinto beans)
- Eggs
- Fish
- Peanut butter/nuts
- Pork
- Sausage/bacon
- Tofu
- Turkey
- Other meal and meat alternatives:.....

### Fats and Sweets

- Cake/cupcakes
- Candy
- Chips
- French fries
- Cookies
- Doughnuts
- Fruit-flavored drinks
- Pies
- Soft drinks
- Other fats and sweets: .....

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 pill 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?

- Yes       No

If yes, on how many days and for how many minutes or hours per day?.....

17. Did you spend more than 2 hours per day watching television and DVDs or playing computer games?

- Yes       No

If yes, how many hours per day?.....

18. Does the family watch television during meals?

- Yes       No

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

- Yes       No

20. Do you smoke cigarettes or chew tobacco?

- Yes       No

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

- Alcohol, beer, or wine
- Steroids (without a doctor's permission)
- Street drugs (marihuana, speed, crack, or heroin)