

## 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)