HOW READY IS YOUR FAMILY?

Please make a check in each box below to let us know changes your family would like to make:

1. Has your family cut back on sweet drinks? This includes sodas, lemonade, Kool-Aid, sweet teas, frappes juices.

- ☐ Not Yet
- ☐ Maybe
- ☐ Thinking About
- ☐ Let's Go!
- ☐ Already Doing It

2. Do you limit fast food to no more than one time per week?

- ☐ Not Yet
- ☐ Maybe
- ☐ Thinking About
- ☐ Let's Go!
- ☐ Already Doing It

3. Do you try to make half your plate fruits and vegetables? Do you try not to get second helpings?

- ☐ Not Yet
- ☐ Maybe
- ☐ Thinking About
- ☐ Let's Go!
- ☐ Already Doing It

4. Are your snacks healthy? Hidden fat, sugar, and calories can be in many snacks.

- ☐ Not Yet
- ☐ Maybe
- ☐ Thinking About
- ☐ Let's Go!
- ☐ Already Doing It

5. Do you try to stay away from high fat and high sugar foods when you shop?

- ☐ Not Yet
- ☐ Maybe
- ☐ Thinking About
- ☐ Let's Go!
- ☐ Already Doing It

6. Are you active as a family 4-5 times a week? Do you limit time in front of screens like the TV or computers?

- ☐ Not Yet
- ☐ Maybe
- ☐ Thinking About
- ☐ Let's Go!
- ☐ Already Doing It

Patient's Name: ____

Date of Birth: ____________________ **Today's Date:** ____________________

July 2018