



2018 Clinch Avenue  
Knoxville, Tennessee 37916

# Healthy Ways Clinic Patient Health Assessment Form

**PATIENT'S NAME:**

**DATE:**

(Please answer from patient's perspective)

Questions	Select 1 response for each question.			
How many snacks do you eat per day?	5 or more	4-5	2-3	2 or less
How many meals do you eat per day?	----	Less than 2 OR more than 3	2	3
How many fresh fruits and vegetables do you eat per day?	None	1-2	3-4	5 or more
How many hours per day do you spend watching TV, using a computer/ iPad/iPhone, or playing video games? (Do NOT count school related screen time)	5 or more	4-5	2-3	2 or less
How many days per week are you physically active?	None	1-2	3-4	4 or more
How many minutes of physical activity/exercise do you do per day?	None	15-30 minutes	30 – 60 minutes	60 minutes or more
How many sugary/sweet drinks do you consume per day? (i.e. chocolate milk, soda, sweet tea, juice, Gatorade/ Powerade, etc)	4 or more	3-4	1-2	None
How many nights per week do you get enough sleep? (Please see chart below for recommended hours of sleep for age.)	None	1-3	4-6	Every night
How many days do you eat out (fast food or restaurants) per week?	4 or more	3-4	1-2	0-1
How many days a week do you eat in front of the TV or while playing computer/video games?	4 or more	3-4	1-2	0-1

Age	Hours of Sleep
2	13
3	12 ½
4	11 ½ -12
5-6	11
7-8	10 ½
9-11	10
12-14	9 ½
15-18	9

Provider Use Only

TOTAL SCORE:

BMI % FOR AGE:

Initial / 6 MO / 1 YR / \_\_YR