

First letter of your FIRST name	First letter of your LAST name	Birth MONTH	Birth DAY
A-Z	A-Z	01-12	01-31
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

PRE POST

County: _____
Site: _____

ID#: _____



1. My child sits and eats meals with an adult

No/rarely
 Sometimes
 Often
 Very often



2. My child eats snack at about the same time every day.

No/rarely
 Sometimes
 Often
 Very often



3. I warn my child s/he will not get a treat if s/he doesn't eat.

No/rarely
 Sometimes
 Often
 Very often



4. My child sees me eat vegetables.

No/rarely
 Sometimes
 Often
 Very often



5. I prepare at least one food that I know my child will eat.

No/rarely
 Sometimes
 Often
 Very often



6. My child eats dinner at about the same time every day.

- No/rarely
 Sometimes
 Often
 Very often



7. I beg my child to eat his/her food.

- No/rarely
 Sometimes
 Often
 Very often



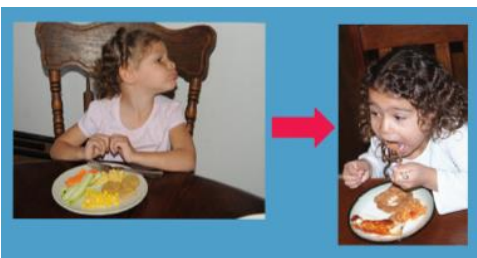
8. I remind my child to keep eating his/her food.

- No/rarely
 Sometimes
 Often
 Very often



9. My child skips meals.

- No/rarely
 Sometimes
 Often
 Very often



10. If my child did not like a food, I avoid serving it to him/her again.

- No/rarely
 Sometimes
 Often
 Very often

11. Please share with us what, if any, changes you have made since taking these classes.

****Please SKIP this question on pre-survey. For post-survey only.****

Thank you!