

BNF Healthy Eating Week Sleep Survey (Primary pupils aged 7 and over)

Use this survey to tell us about what you did before you went to bed last night and how you slept.

Thank you!

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\* 1. How old are you?

- |                               |                                |
|-------------------------------|--------------------------------|
| <input type="radio"/> 7 years | <input type="radio"/> 10 years |
| <input type="radio"/> 8 years | <input type="radio"/> 11 years |
| <input type="radio"/> 9 years | <input type="radio"/> 12 years |

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\* 2. Did you brush your teeth before going to bed last night?

- Yes
- No

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\* 3. How many hours were you asleep last night?

- |   |  |
|---|--|
| <input type="radio"/> Less than 5 hours | <input type="radio"/> 9 hours            |
| <input type="radio"/> 5 hours           | <input type="radio"/> 10 hours           |
| <input type="radio"/> 6 hours           | <input type="radio"/> 11 hours           |
| <input type="radio"/> 7 hours           | <input type="radio"/> 12 hours           |
| <input type="radio"/> 8 hours           | <input type="radio"/> More than 12 hours |

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\* 4. Did you do any of the following in your bedroom just before you went to sleep last night?

- |  |  |
|--|--|
| <input type="radio"/> Read a book or magazine            | <input type="radio"/> Played with a mobile phone or computer |
| <input type="radio"/> Listened to music or an audio book | <input type="radio"/> Played with toys                       |
| <input type="radio"/> Watched a programme or film        |  |

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\* 5. How do you feel this morning?

- Wide awake
- Tired
- Not wide awake or tired



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\* 6. Did you brush your teeth this morning?

- Yes
- No



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\* 7. Did you have breakfast this morning?

- Yes
- No



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\* 8. Did you eat any of these for breakfast? (Tick what you had.)

- |  |  |
|--|--|
| <input type="checkbox"/> Breakfast cereal or porridge  | <input type="checkbox"/> Croissant or pain au chocolat |
| <input type="checkbox"/> Biscuits or cake              | <input type="checkbox"/> Eggs                          |
| <input type="checkbox"/> Crisps                        | <input type="checkbox"/> Fruit                         |
| <input type="checkbox"/> Crumpet                       | <input type="checkbox"/> Sandwich                      |
| <input type="checkbox"/> Cheese                        | <input type="checkbox"/> Toast                         |
| <input type="checkbox"/> Chocolate or sweets           | <input type="checkbox"/> Yogurt                        |
| <input type="checkbox"/> Something else (type here)... |  |



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\* 9. Did you have any of these drinks? (Choose one.)

- |   |  |
|---|--|
| <input type="radio"/> Fruit juice or smoothie   | <input type="radio"/> Flavoured milk or milkshake      |
| <input type="radio"/> Squash  | <input type="radio"/> Hot chocolate                    |
| <input type="radio"/> Coffee  | <input type="radio"/> Milk (or dairy-free alternative) |
| <input type="radio"/> Energy drink  | <input type="radio"/> Tea                              |
| <input type="radio"/> Fizzy drink (with sugar), e.g. cola, lemonade                     | <input type="radio"/> Water                            |
| <input type="radio"/> Fizzy drink (no sugar), e.g. zero sugar cola, sugar free lemonade |  |
| <input type="radio"/> Something else (type here)...                                     |  |