Assessing Beverage Intake in Children and Adolescents: State of the Science, Recommendations, and Resources for Evaluation

Anna H. Grummon, Rebeccah L. Sokol, Christina A. Hecht and Anisha I. Patel

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I. Introduction and Background

**Beverage Consumption is Important for Children’s Health and Development**

Beverage consumption is an important contributor to the health and well-being of children and adolescents. Beverages can either promote good health and development, or impede it. For example, consumption of sugar-sweetened-beverages (SSBs) such as sodas, sports drinks, and fruit drinks increases youth’s risk of obesity, 1-3 dental caries, 4 and metabolic syndrome. 5 Similarly, adolescents who consume energy drinks report lower self-rated health, are more likely to have behavioral and academic problems, 6 and have an increased risk of poor mental health, obesity, tooth decay, type 2 diabetes, and risk-seeking behaviors. 7 On the other hand, drinking water improves children’s cognitive functioning, 8-11 may help to limit weight gain 12,13 and, if fluoridated, may help prevent dental caries. 14,15 Consumption of low-fat or fat-free milk is also recommended, as it facilitates proper bone development. 16,17

Because beverage consumption contributes to children’s health and developmental outcomes, researchers, policymakers, and practitioners are interested in monitoring children’s beverage consumption. Monitoring beverage intake helps both to assess general trends over time, and to estimate changes in consumption in response to specific interventions, such as educational campaigns or environmental or policy changes targeting beverage consumption.

A variety of methods exist to assess children’s beverage consumption, most of which can be categorized into one of five major types: recalls, diaries, questionnaires and screeners, observations, and direct measurements (see Table 1). Each of these methods has been used for assessing beverage intake in children. In addition, each has its own unique advantages and limitations, and no one technique will be ideal in all settings. 18,19 In addition to tradeoffs among methods, measuring beverage intake in children presents additional challenges, as children have more variable diets than adults and tend to have greater difficulty accurately reporting their dietary behaviors. 19-22

For these reasons, individuals interested in assessing children’s beverage intake need guidance: they need to know what types of methods are available, to learn the basics of how to implement those methods, and to understand some of the tradeoffs involved in using each method. Additionally, because each method brings its own limitations, consumers of the scientific literature also need to know what methods are being used to assess beverage intake in children; this information paints a picture of the strengths and limitations of recent research. This report attempts to address these two goals. Specifically, we aim to:

1. Describe types of available methods, including their advantages and limitations
2. Provide resources and references for evaluators hoping to measure beverage intake among children
3. Describe the recent state-of-the-science in measuring beverage intake in children

There are other excellent resources available to assist researchers in selecting a dietary assessment method. 23,24 However, none of these resources focus specifically on beverage intake, and, in general, their focus is on self-reported measures, rather than on a larger set of assessment options including objective measures.
Methods Used to Develop the Report

This report draws on three main sources. First, others have written extensively on dietary assessment, and we both reference this work and encourage readers looking for more detail to review these resources directly. Resources we found particularly useful include textbooks edited by Willett25 and by Hu26 as well as a chapter of Nutrition in the Prevention and Treatment of Disease by Thompson and Subar.19 We also drew on a number of review articles, including by Burrows and colleagues,27 McPherson and colleagues,28 Serdula, Alexander, Scanlon & Bowman,29 Livingstone and colleagues,30,31 and Rutishauser.32

Second, we conducted a systematic review of peer-reviewed literature from 2007-2017 to identify recent studies that assess beverage intake in children and adolescents.33 This review allowed us to determine what methods are commonly used to assess children’s beverage intake, as well as which assessment methods have been validated and in what populations. Additionally, the review yielded a repository of specific tools (e.g., questionnaires) researchers have used to assess children’s beverage intake, many of which are detailed below.

Finally, this report draws on our searches of the grey literature, including government manuals and reports, online versions of questionnaires or other measurement tools, websites for commercial products that can assist with measuring children’s intake, and online databases of measurement tools (e.g., the National Collaborative on Childhood Obesity Research [NCCOR] Measures Registry).

The report contains three main sections. First, we provide a brief overview of general considerations for measuring beverage intake in children and adolescents, with resources for readers looking for additional detail. Second, we review five main types of assessment methods, including a description of how to implement the method, recommendations for use or best practices, advantages and disadvantages, and specific resources and references to help researchers wishing to implement these methods. Rather than providing a completely comprehensive review of all available methods, or all features of those methods, we hope that this section provides a useful starting point for researchers and evaluators as they select an assessment technique. Finally, in an appendix to be released upon publication of the systematic review, we will provide a short summary of findings from the review, focusing on the state-of-the-science of measuring children’s beverage intake.

II. General Considerations

Introduction

In this section, we briefly describe several key issues to consider when assessing beverage intake in children and adolescents. For readers seeking more detailed information, we recommend resources such as the National Cancer Institute’s Dietary Assessment Primer24 and the National Collaborative on Childhood Obesity Research’s Measures Registry User Guide: Individual Diet.23
Determining the Beverage Intake Variable of Interest

When selecting a beverage intake assessment method, a first step is to clearly define exactly what type of beverage intake is of interest. We focus on two beverage intake variables that researchers may be interested in measuring:

- Long-term, usual intake of one or more beverage category. For example, a researcher interested in bone health might wish to estimate children’s usual intake of milk. Long-term usual intake is typically of most interest to public health practitioners and researchers, as usual beverage intake is what is most relevant to the development of important conditions such as obesity, diabetes, and tooth decay.

- Recent or acute intake of one or more beverage category. For example, a physician may wish to assess a child’s recent intake of beverages that could explain a patient’s gastrointestinal illness. Recent intake is relevant for the development of acute conditions such as allergic reactions, gastrointestinal illness, or migraines.

As discussed in Section III, some assessment methods query individual’s usual intake, while others ask about recent intake (e.g., beverages consumed yesterday). Because individual dietary intake varies considerably day-to-day, assessing recent (acute) intake will rarely reflect an individual’s usual intake. When researchers use measures that capture recent intake, such as recalls, diaries, and observations, they cannot assume participants’ responses represent their long-term intake. If long-term intake is of interest, researchers have two options. First, in most cases, usual intake at the group-level (rather than the individual-level) can be estimated by averaging recent intake from a representative sample. For example, mean usual intake of fruit juice among children in the U.S. can be estimated by calculating the mean intake of fruit juice on a 24-hour recall collected on a representative sample of American children. A second approach is to use an assessment method that queries long-term intake, such as a frequency questionnaire that asks participants to report their usual beverage intake. Whatever the approach used, this consideration is especially important for beverage consumption, as many categories of beverages are consumed episodically and thus individual intake has greater day-to-day variation than intake of ubiquitously consumed dietary components (e.g., macronutrients).

Self-Report vs. Objective Measures

Another key consideration is whether to measure children’s beverage intake using a self-report measure, such as a questionnaire or recall, or an objective measure such as observation or direct measurement. (Other objective measures of dietary intake include biomarkers; however, to our knowledge, no biomarkers have been identified specifically for assessing beverage intake). Self-reported measures are common in dietary research, and some argue that they may be the only feasible approach to assessing usual intake in community-dwelling individuals. Self-reported methods do have some benefits. For example, self-reported data can be collected by phone or online from children across a wide geographic area without researchers needing to visit data collection sites. Additionally, self-reported measures can query children’s usual intake, whereas objective measures such as observations and direct measurements of weight and volume typically assess recent intake (e.g., a single meal or single day). Additionally, retrospective measures like recalls do not
cause children to change their behaviors, whereas children who know they are being observed may change their beverage consumption habits as a result.

Despite these benefits, self-report measures have a number of key limitations. A key issue is that self-reported measures are prone to bias: participants often systematically misreport aspects of their dietary intake, including their beverage intake. Children may misestimate portion size, fail to report items they did consume or report consuming items they did not have, be unable to accurately report details about items they did not purchase or prepare, have cognitive difficulty estimating usual intake, or misreport intake because they are unmotivated or because of social desirability bias. Misreporting often varies with participant characteristics, such as obesity status, gender, age, race/ethnicity, and socioeconomic status. In turn, systematic bias in beverage intake data can lead to biased estimates of usual intake and of the relationship between beverage intake and other exposures or outcomes of interest. Concerns about the validity of self-reported dietary intake have led some to suggest that their use be abandoned altogether in favor of objective methods. Further, while currently available objective measures are resource-intensive, they may be more feasible to implement with youth than with adults because youth spend a significant portion of their time in formal institutions such as childcare facilities and schools – locations where objective measures may be easier to collect because in many cases, everyone eats at similar times in one or a few locations, and because standardized meals are often served. Emerging technologies, such as digital photography and image recognition, may increase the feasibility of collecting objective dietary intake data from large or community-based samples, but more work is needed to develop and validate these methods.

**Age Range**

Another issue to consider when assessing beverage intake in children and adolescents is the age range of the target population, as age can influence both children’s cognitive ability to self-report their intake as well as their motivation to report accurately. Young children (<7 or 8 years) are unlikely to be able to accurately recall their recent dietary intake and cannot accurately report usual consumption frequency. Thus, researchers wishing to assess beverage intake in this age group must either rely on proxy report or use objective methods (observation, direct measurement). Typically, proxies are the child’s parent or caregiver. Some studies have found that parents are able to accurately report what their child consumes at home. However, proxy-report may be influenced by the same sources of errors as self-report in general, including that proxies may have difficulty remembering what was consumed, struggle to estimate portion size, or misreport due to social desirability bias. Unfortunately, misreporting may be related to both the proxy’s and the child’s characteristics. For example, researchers have found that parents’ degree of over- or under-reporting on 24-hour recalls of their children’s (ages 2-9 years) intake is related to both the child’s actual body mass index as well as the proxy’s perception of the child’s weight. Further, many young children spend a substantial portion of their day in childcare facilities or schools, and parents and caregivers may not know what their child consumed while away-from-home.

As children get older, they become increasingly able to report their own intake. For example, population-based surveys such as the National Health and Nutrition Examination Survey ask elementary school-age children (6-11 years) to report their own intake with the
assistance of a parent or caregiver. However, children in this age range can only accurately report their intake over very short periods, e.g., the previous meal. Once youth reach adolescence (age 12 or older), they are generally considered capable of self-reporting their own dietary intake. However, adolescents may still struggle to accurately self-report their beverage intake depending on their literacy level, attention span, capacity for abstract reasoning, and motivation. Further, adolescents, like adults, struggle to accurately estimate portion size.

III. Assessment Methods

Introduction
In this section, we begin by providing an overview of each method, as well as key advantages, limitations, and resources related to these methods (Table 1). Next, we provide additional details on recommendations for implementing each method. This information is not meant to be exhaustive, but to provide an introduction to the major methods for assessing beverage intake in children and adolescents, as well as considerations for using these methods. We give special attention to resources for assessing beverage intake with questionnaires or screeners, as this method typically requires the fewer resources to implement, and thus may be feasible to conduct in a variety of evaluation settings (though note the limitations of self-report measured discussed above). Table 2 provides a compilation of available questionnaires for assessing beverage intake in children, as well as brief descriptions of their properties (e.g., validity, reliability, types of beverage intake assessed).
Table 1. Overview of Beverage Consumption Assessment Methods Reviewed

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<th>Description</th>
<th>Advantages</th>
<th>Limitations</th>
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| Recalls | Respondent reports all beverages consumed over the referent period (usually the preceding 24 hours or preceding day). Respondents generally give detailed information on items consumed, including product descriptions (e.g., low-fat vs. high fat milk, sweetened or unsweetened coffee) and amount consumed. Multiple passes may be used to increase accuracy and completeness. Recalls can be interviewer- or self-administered. | - Allow for precise estimation of an individual’s recent consumption  
- Can estimate usual intake at the group-level  
- Low literacy if interviewer-administered  
- Less challenging for participants because of short referent period (usually 24 hours)  
- Do not cause participants to change their behavior  
- Open-ended, so can be used across diverse populations | - Self-report measure; participants may not report accurately, and misreporting may be associated with participant characteristics  
- Young children cannot accurately recall their own intake; proxy-report will be needed for young children  
- Unless multiple recalls are collected, data may not represent an individual’s usual beverage consumption  
- Beverages consumed may need to be coded (e.g., categorized into groups) before analysis | - Procedure manuals for national studies provide details on administering 24-hour recalls with the multi-pass method: [https://perma.cc/TSTW-R293](https://perma.cc/TSTW-R293)  
- Multiple-pass, interviewer-administered recalls can be collected via commercial software (e.g., the Nutrition Data System for Research [NDSR]45)  
- The National Cancer Institute offers the ASA-24, free software for collecting self-administered multiple pass 24-hour recalls in English or Spanish: [https://perma.cc/WJ4W-KAUV](https://perma.cc/WJ4W-KAUV), The ASA-24 |
| Diary  | Respondent records, in real time, all beverages consumed, including product descriptions and the amount consumed. Typically conducted over one or more days. Respondents may also weigh items consumed to report portion sizes with greater accuracy. Can be completed on paper or electronically. | - Allow for precise estimation of an individual’s recent consumption; if several days are collected, may provide a picture of usual consumption for that time of year  
- Real-time reporting may increase accuracy and detail of reports  
- Weighed diaries accurately reflect portion size | - Self-reported measure; participants tend to underreport intake. Under-reporting may be related to participants’ characteristics (e.g., body mass index, sex, socioeconomic status)19,27,28 and may be worse for older compared to younger children.46  
- Unless multiple diaries are collected, diaries may not represent an individual’s usual dietary intake  
- Respondents must be highly literate. Young children cannot complete on their own.  
- High participant burden  
- Recording consumption in real-time may change participants’ dietary behaviors  
- Beverages consumed may need to be coded prior to analysis | - The NDSR software (see also above) can be used to collect and analyze diary data.49  
- The National Heart, Lung, and Blood Institute offers printable diaries ([https://perma.cc/Y3YD-YTLY](https://perma.cc/Y3YD-YTLY)), though these are not specifically designed for children nor for research purposes. |
## Measuring Beverage Intake in Children and Adolescents

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| Questionnaires and screeners | Respondent indicates usual frequency of consumption of specific beverages, sometimes over a specific referent period (e.g., last week, month, or year). Questionnaires assess a finite of beverages using pre-specified response categories (e.g., times per day, per week, or per month). In some questionnaires, usual portion size is also assessed. Brief measures (sometimes called ‘screeners’) focus on assessing consumption of one or a small number of items (e.g., sugar-sweetened beverages). Can be interviewer- or self-administered. | • Can estimate respondents’ usual beverage intake over longer periods  
• Less resource intensive to administer than other methods  
• Focused questionnaires and screeners have low respondent burden  
• Do not cause participants to change their behavior  
• Lower data processing costs compared to diaries or recalls. | • More measurement error than other methods (less detail about beverages, less accurate portion size estimation)  
• Can be cognitively challenging; may be difficult for respondents, particularly younger children, to estimate their usual intake  
• Closed ended; need to be detailed to respondent population or could miss consumption of key beverage categories  
• Most suitable for ranking individual consumption relative to others, not for estimating precise intake | See Table 2                                                                 |
| Observation          | Researchers observe and visually estimate beverage consumption, generally using standardized forms. Typically used to estimate consumption during a single meal or snack.                                                                 | • Does not rely on self-report, reducing measurement error and bias  
• Because researcher collects data (rather than participants self-reporting), measure is appropriate for low-literacy populations  
• Low respondent burden  
• Relatively precise estimation of recent intake  
• Can be used with children of any age, since does not depend on their cognitive abilities; avoids use of proxy-report for young children | • May be more resource-intensive than self-reported measures  
• Unless multiple observations are conducted, data may not represent an individual’s usual dietary intake  
• Require staff to visit the locations where children are observed, limiting geographic scope  
• Observers need extensive training prior to data collection  
• Difficult to visually estimate consumption of beverages consumed in opaque containers (e.g., milk or juice cartons, opaque cups or bottles, cans) | • Ball, Benjamin, and Ward (2007) describe a widely-used, reliable, and validated procedure for observing children’s food and beverage intake in child care settings.37  
• Hanks and colleagues48 and the Food and Brand Lab’s website describe the popular and validated ‘quarter-waste’ method for visual estimation: https://foodpsychology.cornell.edu/discoveries/quarter-waste-method.  
• Kenney and colleagues49 describe a similar procedure that estimates amount wasted in thirds rather than quarters.  
• Grummon and colleagues provide an observation form for estimating middle school students’ beverage consumption during school lunch time.50 |
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| Direct measurement of weight or volume | Researchers collect direct measurements of weight or volume of beverages consumed by participants. Often done using ‘plate waste’ methods, in which the researcher measures weight or volume of beverages before they are served, then measures the weight or volume of any leftover items; consumption is estimated as the difference in these two measures. Often used in settings where children are served similar items or standardized meals (e.g., childcare or school meal settings). | • Does not rely on self-report, reducing measurement error and bias  
• Provides accurate estimation of recent intake; if spills and trades are accounted for, can be more accurate than observations  
• Provides detailed information on types and amounts of beverages consumed  
• Can be conducted without children’s knowledge they are being measured, reducing the potential for behavior change in response to measurement  
• Can be used with children of any age, since does not depend on their cognitive abilities; avoids use of proxy-report for young children. | • Resource-intensive, particularly if individual intake is tracked  
• Trained research staff, scales/measuring equipment, and space to conduct measurements are needed  
• Multiple days of measurements must be collected to capture usual intake  
• Investigators must visit the sites where data is collected, limiting geographic scope  
• May not be feasible in settings where children are not eating standardized meals  
• Difficult to link consumption to an individual unless trays or cups are marked. | • The Smarter Lunchroom Movement provides a step-by-step guide to assessing children’s intake using direct measurements in school cafeterias, as well as free spreadsheets for collecting data: [https://www.smarterlunchroom.com/scorecard-tools/measuring-consumption-smarter-lunchroom-tray-waste](https://www.smarterlunchroom.com/scorecard-tools/measuring-consumption-smarter-lunchroom-tray-waste).  
• The USDA also provides a brief, non-technical description of ‘plate waste’ measurement techniques, though note that this document focuses on estimating the percentage of foods/beverages children waste (do not eat) rather than the amount they consume: [https://www.ers.usda.gov/webdocs/publications/43131/31216_efan02009.pdf?v=41423](https://www.ers.usda.gov/webdocs/publications/43131/31216_efan02009.pdf?v=41423). |
A. Recalls

Recommendations for Use

Use a ‘multiple pass’ method. Standard practice, used by major nutrition surveillance surveys such as the National Health and Nutrition Examination Survey (NHANES), is to administer recalls using a multi-pass method in which the respondent reviews her intake more than once in order to capture information about consumption of foods or beverages the respondent may have forgotten on earlier passes. Beverages are often forgotten in a first pass, so using multiple passes is especially important for researchers interested in beverage intake. The United States Department of Agriculture (USDA) Automated Multiple Pass is considered the “gold standard” multi-pass method. In this method, the follow steps are taken:

1. The respondent gives a “quick list” of foods and beverages consumed during the referent period, without taking questions from the interviewer
2. The interviewer probes for consumption of 9 foods and beverages individuals often forget to report
3. The interviewer probes for the time of each eating occasion,
4. The interviewer probes for more detailed information about each item consumed (e.g., asking for portion size, preparation methods), and
5. The interviewer and respondent engage in a final review, with the interviewer asking questions about any reported items not yet reviewed.51

Interviewer-administered vs. self-administered recalls. Recalls are often interviewer-administered (either in person or by phone), and some recommend this as best practice, as interviewers can improve the accuracy and richness of the data by probing for additional details and forgotten items.19 Interviewer-administered recalls are also appropriate for low-literacy populations.52,53 Interviewers should be trained before collecting data to ensure they probe correctly and consistently. However, recalls can also be self-administered. For example, the National Cancer Institute developed a free, online tool for self-administered recalls, the Automated Self-Administered 24-hour Recall (ASA 24).54 These systems may reduce the cost of collecting recall data.

Portion size. Providing respondents with training can help them better estimate portion size, but training is time- and resource-intensive.30 Booklets explaining portion sizes, or with visual props may help respondents more accurately estimate portion size, though there is debate about whether they are useful for younger children and adolescents.31

Day of the week. Day of the week can affect what participants eat and drink. Ideally, investigators collect data on consumption during each day of the week in roughly equal proportions.55 When more than one day of intake is collected from the same participant, it is standard practice to collect one weekday and one weekend day.

Proxy vs. self-report. Children over age 12 are generally able to recall their intake over the past day,31 younger children (ages 8 or 9) may only be able to recall over shorter periods, such as a single meal.21,30 In general, it is recommended that a proxy report on behalf of children under the age of 10, typically with the child present.55
B. Diaries

Recommendations for Use

Number of days of data collection. Collecting more than one day is recommended if the investigator wishes to approximate ‘usual’ consumption. However, respondents may become fatigued if they are asked to complete the diary over too long a period, and consequently report less accurately later in the data collection period. Collecting more than 4 days of diary is discouraged.19,56

Training respondents and reviewing records. Respondents need to be trained in how to complete the diary and given instructions on the amount of detail the investigator wishes to collect. In some studies, investigators review the first day of the diary with the participants before the participant completes additional days, providing feedback or clarification. When possible, it is recommended that a trained interviewer review the entire diary with the respondent to collect any missing details.

Modifications. For investigators interested specifically in beverage consumption, and not in consumption of foods, diaries could be modified to ask respondents to report on their beverage consumption only. Additionally, some diaries use a “checklist” form in which participants check each item they consume from a pre-specified list. Researchers interested in intake of beverages generally, or of specific beverage types, could employ this method, rather than asking participants to record all foods and beverages they consume.

C. Questionnaires and Screeners

Recommendations for Use

Portion size. Some frequency questionnaires capture portion size. This information can be captured either by asking respondents for their usual portion size in separate questions, or by indicating a standard portion size in the question itself and asking participants how many of these defined servings they typically consume during the specified period. When portion size is assessed, investigators can compute a quantitative or semi-quantitative estimate of total consumption of a particular beverage type or types over the referent period. When portion size is not captured, investigators must either rely on frequency information alone (e.g., use ‘times consumed per day’ in analyses) or make an assumption about the portion size usually consumed by participants in their sample.

Some researchers recommend using questionnaires without asking respondents to report serving sizes, as this may reduce participant burden.19,55 However, others recommend asking respondents to report their usual portion size, as this may improve the accuracy of the questionnaire.19,57

Beverage categories to assess. Unlike recalls and diaries, in which participants can report all items they consume, questionnaires capture intake only for the pre-specified list of items. Thus, it is crucial to ensure this list is appropriate for use in the target population. When possible, investigators should pilot test their questionnaires with members of the target population and/or with others familiar with measuring intake in this population.

It is difficult to assess consumption for items consumed both as single items and in mixtures. While this issue is often more problematic for assessing foods than beverages,
investigators should consider whether mixed beverages are commonly consumed in their target population (e.g., juice diluted with water, coffee with milk added). If mixed beverages are of interest, the investigator can either: (a) ask the respondent to estimate intake of each component individually (e.g., separately estimate juice and water intake), which may be challenging for respondents to do, or (b) could ask separate questions about each item, which could cause some respondents to double count intake of some beverages.19

Time frame. Frequency questionnaires differ in the time frame, or referent period, over which intake is assessed. Some questionnaires and screeners ask about recent actual intake. For example, the Youth Risk Behavior Survey (YRBS) asks respondents about their beverage intake over the past 7 days.58 Other questionnaires assess usual or habitual intake over a longer period; for example, the Block Questionnaire for Ages 2-7 asks about a child’s usual eating and drinking habits in the past 6 months.59

Longer referent periods are difficult for children. Specifically, research finds that while children can report their dietary intake more accurately over very short referent (a recent meal, past 24 hours), they may not be accurate when reporting over longer referent periods.21,30 Additionally, while usual beverage consumption is often of interest, it is more cognitively complex –even for adults – to remember and estimate one’s usual consumption over a longer period than it is to report consumption at a recent meal or over the past day.

D. Observation

Recommendations for Use

Training. Observers should be trained prior to data collection to ensure consistent and accurate reporting. Training typically includes practice visually estimating portion size, watching unobtrusively, and using any standardized forms correctly. Investigators might wish to “certify” their data collectors before collecting study data. For example, Ball and colleagues report certification procedures for data collectors observing meals in child care settings.47 Some studies also employ quality control checks during data collection periods in which observation forms are reviewed by a member of the research team (see, e.g., Harnack and colleagues60), or the same child/children are observed by multiple researchers and agreement among observers is calculated.

Observer-to-child ratio. When possible, each observer should be matched 1:1 with a child to observe. However, this is often not feasible. Studies suggest that observers can accurately observe up to 3 children at a time47,61 and some studies ask observers to observe even more children at a time (e.g., Kenney and colleagues49 conducted a study in which a single data collector recorded intake for up to 35 children at a time).

More than one observer. Because different observers may record child’s intake differently, it may be helpful to establish that observers are consistent with one another. To do this, more than one researcher must observe the same child/children, and estimates of intake are compared across the observers, for example using agreement statistics such as Cohen’s kappa62 or Krippendorff’s alpha.63 A Cohen’s kappa of 0.61–0.80 is considered ‘substantial agreement’ and 0.81–0.99 is considered ‘almost perfect agreement,’62 depending on research needs, either cutoff might be used when establishing inter-rater consistency.
Krippendorff suggests that alpha >0.80 demonstrates adequate inter-rater reliability in many settings.64

Conducting the observation. Observers should attempt to watch children unobtrusively. While children will often know or notice they are being observed, observers should not talk or interact with children.

Number of observations. Investigators wishing to assess usual intake may wish to collect multiple observations, as children’s intake can vary greatly from one meal to the next, or one day to the next, and thus one assessment may not reflect children’s usual consumption patterns. Single observations can be used to estimate group-level average intake across the sample, but should not be used to predict health outcomes.28

Portion size. Portion size can be estimated in various ways. For estimating beverage intake, observers might record the number of ounces they observe the child consuming based on starting/ending amounts observed, or based on number of sips they observe the child taking.50 Another popular method is the ‘quarter-waste’ method in which researchers estimate consumption in quarters of the starting amount. Hanks and colleagues48 found that the quarter-waste method correlated well with weighed estimates of intake for beverages (range of correlation coefficients for beverages: 0.67 to 0.93), and performed better than the half-waste method. A similar method was validated by Kenney and colleagues,49 who found that visual estimates of children’s consumption in four categories (0% or ‘none’, 33% or ‘some’, 66% or ‘most’, and 100% or ‘all’) produce accurate estimates of total beverage servings consumed (correlation coefficient = 0.92), though this method performed less well for estimating water consumption specifically (correlation coefficient = 0.48).

E. Direct Measurement of Weight or Volume

Recommendations for Use

Individual vs. aggregate intake. Direct measurement can be used to assess individual’s intake or aggregate intake of a group (e.g., a classroom). To assess individual intake, each child’s starting and ending amount of each beverage must be measured and recorded. Investigators must therefore devise a system to pair each child’s starting and ending amounts, for example, by placing ID numbers on each child’s tray or cup. To assess aggregate intake, the total starting amount is calculated by weighing/measuring each type of item served and multiplying this measurement by the number of times this item was served. Individuals’ beverage leftovers are combined, often separated by beverage type (e.g., orange juice leftovers are combined separately from milk leftovers) and the aggregated leftovers are measured. Investigators then estimate the total amount consumed by all children by subtracting the amount leftover from the starting amounts. Mean individual intake can be calculated by dividing this total amount consumed by the number of children at the meal.

Assess only edible portions consumed. Only the edible portion of beverages should be ‘counted’ toward estimates of total amount consumed. In practice, this means that if a researcher weighs a pre-meal beverage while it is still in its serving container, the investigator must either also weigh leftovers in the serving container (so that the weight of the container is ‘differenced out’ when calculating total amount consumed). Or, the weight of an empty container must be measured and this weight subtracted from the starting weight.
**Stay out of sight.** Whenever possible, children should be unaware that their intake is being monitored, so that they are less likely to change their consumption in response to being measured. Investigators might choose to mark children’s trays or cups unobtrusively (e.g., a sticker underneath the tray), and might also weigh/measure beverages in a separate room, out of children’s sight.

**Account for spills and trades.** To increase accuracy, investigators should (unobtrusively) observe children during the meal and record (a) when children take additional servings of any items of interest (and, if individual intake is being assessed, which children take additional servings and how many each takes) and (b) whether any beverages are spilled, and if so, about how much was spilled. Spills should be subtracted from estimates of total amount consumed. Additionally, for investigators wishing to measure individual intake, observers should record if individual children swap or trade any beverage items.

### F. Resources for Assessing Children’s Beverage Intake Using Questionnaires and Screeners

Questionnaires and screeners are often less resource intensive than the other types of beverage intake assessment methods, and thus many investigators are interested in using these instruments. Table 2 provides a number of resources for assessing children’s beverage intake using questionnaires and screeners, including information on time-to-complete the questionnaire/screener, literacy level required, types of beverages assessed, languages available, validity and/or reliability information, and recent (past ten years) examples of the instruments’ use or validation in low-income and/or minority populations.

This table is not meant to be an exhaustive list of all available questionnaires and screeners, but rather illustrative of a number of options available for researchers. We have included in this table all of the questionnaires and screeners that we identified in our systematic review as having recently published (2007-2017) primary data on criterion validity (correlation with a “gold-standard” method) and/or reliability.
### Measuring Beverage Intake in Children and Adolescents

**Table 2. Questionnaires Assessing Beverage Intake in American Children and Adolescents**

**Key & Notes:**
The questionnaires included here are organized by the age range they were developed to assess, sorted from youngest to oldest based on the lower end of the age range (e.g., a survey used among children ages 3-12 years is listed before one used with ages 5-8 years). Grade levels are used in place of ages as needed. This table is meant to provide a resource for researchers looking to assess beverage intake in a particular population (e.g., a certain age group, literacy level, racial/ethnic background, or income level), using a particular language, with specific properties (e.g., validated), or focused on particular beverage categories. Each row describes a different questionnaire or screener; columns describe key features of that instrument.

- ✔️ = Criterion validity and/or any type of reliability has been assessed for this questionnaire. Does **not** mean that validity/reliability were adequate, only that these properties have been assessed and reported on for this questionnaire. See validity and reliability columns for additional details.
- 🏞️ = Questionnaire has been used and/or validated in a racially diverse sample
- 💲 = Questionnaire has been used and/or validated in a lower-income sample
- 📚 = Literacy level assessed, and questionnaire is appropriate for as 8th grade reading level or lower

<table>
<thead>
<tr>
<th>Instrument</th>
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<tr>
<td>California Health Interview Survey (CHIS), adult respondent</td>
<td>Questions can be found here: <a href="http://healthpolicy.ucla.edu/chis/design/Pages/questionnairesEnEnglish.aspx">http://healthpolicy.ucla.edu/chis/design/Pages/questionnairesEnEnglish.aspx</a> (English) and here: <a href="http://healthpolicy.ucla.edu/chis/design/Pages/Questionnaires%20(Translated).aspx">http://healthpolicy.ucla.edu/chis/design/Pages/Questionnaires%20(Translated).aspx</a> (Translated)</td>
<td>Proxy report of child’s (ages: 0-11 years) consumption of beverages (number of bottles, cans) ‘yesterday.’</td>
<td>~15 minutes for all items about child,[n] beverage items should take &lt; 5 minutes</td>
<td>Not reported</td>
<td>Not reported for beverage intake</td>
<td>Not reported for beverage intake</td>
<td>• English • Spanish • Cantonese • Mandarin • Korean • Vietnamese • Tagalog</td>
<td>• Developed for use in large samples of Californians that would include minorities and low-income households. • Soda (non-diet) • Sweetened fruit drinks, sports and energy drinks</td>
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### Measuring Beverage Intake in Children and Adolescents

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<tr>
<td>Self-Administered Questionnaire for assessing water intake and intake of other beverages</td>
<td>See Gorelick et al. (2008),66</td>
<td>Developed by to assess water exposure (including usual water consumption) among emergency department patients.66 Proxy reports on child's (ages: 0-18 years) consumption (yes/no) of beverages during the child's current illness.</td>
<td>Not reported</td>
<td>Appropriate for use in lower-literacy populations: Flesch-Kincaid score was 5.3 (~5th grade reading level).66</td>
<td>Not reported</td>
<td>In parents of children presenting at an emergency department (n = 94), next-day test-retest reliability was adequate (kappa &gt; 0.40) for items related to usual water consumption and for recent consumption of tap water, bottled water, juice, milk, infant formula, soda, sports drinks, and electrolyte drinks. Inter-rater agreement among caregivers of the same child was adequate for these beverage categories, except for juice (kappa = 0.16).66</td>
<td>English</td>
<td>Validation: Reliability was assessed in a relatively diverse sample of parents (63% white, 19% African American, 11% mixed race, and 12% Latino).66</td>
<td>Usual water consumption Consumption of the following beverages during the child's current illness: Tap water Bottled water Juice Milk Infant formula Soda Sports drinks Electrolyte drinks</td>
</tr>
<tr>
<td>Food Frequency Questionnaire (FFQ) for 1-3-year-old children from tri-ethnic, low-income families</td>
<td>Developed by Klohe et al. (2005)67 for use with low-income white, Hispanic, and African American children.67</td>
<td>Proxy reports child's (ages: 1-3 years) usual intake (frequency and qualitative portion size) of foods and beverages using 191 items.</td>
<td>Not reported</td>
<td>Not reported</td>
<td>In a sample of 52 parents, most children (94%) were classified in the same or within one quartile for servings per day of sweetened beverages by the FFQ and a 3-day diary. Response to the FFQ significantly correlated with 3-day diaries for consumption of orange juice, apple juice, sweetened beverages, reduced-fat milk, and whole milk.67</td>
<td>In a sample of 25 parents, 2-week test-retest reliability for sugar-sweetened beverage consumption was 0.74.67 Inter-rater reliability among 2 caregivers/parents reporting on the same child's intake ranged from kappa = 0.16 (juice) to 1.00 (sports drinks).</td>
<td>English</td>
<td>Validation: Validated among white, Hispanic, and African American low-income mothers (all were participants in the Special Supplemental Nutrition Assistance Program for Women, Infants, and Children [WIC] with incomes ≤ 200% of the Federal Poverty Level),67</td>
<td>Sweetened beverages (sodas, ades, and sweetened teas) Orange juice Apple juice Reduced-fat milk Whole milk</td>
</tr>
<tr>
<td>Food Frequency Questionnaire for children of Mexican descent</td>
<td>Developed by Vera-Becerra et al. (2016) for use measuring food acculturation among children of Mexican descent.68</td>
<td>Proxy reports child's (ages: 1-6 years) frequency of consumption of 30 items.</td>
<td>Not reported</td>
<td>Not reported</td>
<td>In Mexican-descent children ages 1-6 years from the U.S. and Mexico, responses to the questionnaire were significantly correlated with consumption reported on a 24-hour recall for whole milk, low-fat milk, soda, fruit drinks, and 100% juice (both fresh and canned).68</td>
<td>Not reported</td>
<td>Spanish</td>
<td>Validation: Validated in a sample of Mexican-origin children in urban areas of the U.S. as well as urban and rural areas of Mexico.68</td>
<td>Whole milk Low-fat milk Soda Fruit drink/aquas frescas 100% juice (fresh) 100% juice (canned)</td>
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<td>Child Food and Beverage Intake Questionnaire (CFBIQ) (embedded within the LA County Women, Infants, and Children [WIC] Survey)</td>
<td>Items can be found in Koleilat and Whaley (2016) and at the Los Angeles County WIC Data website: <a href="http://lawicdata.org/survey/">http://lawicdata.org/survey/</a></td>
<td>Proxy reports child’s (grades: preschool) usual intake of beverages. Some items capture frequency only; other are semi-quantitative.</td>
<td>3 minutes</td>
<td>Not reported</td>
<td>Validated against three 24-hour recalls with WIC participants with children ages 2-4 years (n = 70). Correlation coefficients between CFBIQ and 24-hour recalls were significant for milk, chocolate/sweetened milk, fruit drinks, 100% fruit juice, sweetened drinks and total sugar-sweetened beverages (composite of fruit drinks sodas, and sweetened drinks). CFBIQ did not correlate significantly with 24-hour recall estimates of soda consumption.</td>
<td>In a sample of 70 WIC participants with children ages 2-4-years, test-retest reliability was adequate for all beverage categories assessed (range of ICCs = 0.48-0.87).</td>
<td>• English • Spanish</td>
<td>• Milk • Chocolate or sweetened milk • 100% fruit juice • Fruit drinks • Sweetened drinks (e.g., Sunny Delight) • Regular sodas</td>
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<tr>
<td>Block Kids Questionnaire for Ages 2-7</td>
<td>Available from Nutrition-Quest</td>
<td>Proxy reports on 90 items assessing child’s (ages: 2-7) usual intake (frequency and portion size) over the past 6 months.</td>
<td>~30 minutes for the full questionnaire</td>
<td>Not reported</td>
<td>None reported</td>
<td>None reported</td>
<td>English</td>
<td>Use: Hare et al. (2012) used in a primarily African-American sample with about 50% of households earning &lt;$30,000/year.</td>
<td>• Sweetened (sugary) beverages • Fruit juice</td>
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<tr>
<td>Block Food Screeners for Ages 2-17</td>
<td>Available from Nutrition-Quest.⁷⁹</td>
<td>Proxy or child reports on child’s (ages: 2-17 years) consumption of items 'yesterday' or 'last week' (depending on version)</td>
<td>10-12 minutes for the full screener</td>
<td>Approximately 3rd grade reading level⁷¹</td>
<td>Validated for use in 10-17-year-old children for assessing fruit/fruit juice, vegetables, potatoes, whole grains, saturated fat, meat/poultry/fish, dairy, legumes, sugar, and average daily glycemic index and load.⁷² Mulasi-Pokhriyal et al. (2013): used in a sample of Hmong-American children ages 9-18, but found that it did not validly capture milk intake compared to a 24-hour recall.⁷³ No other studies of validity for assessing beverage intake reported.</td>
<td>None reported</td>
<td>• English, Spanish ('last week' version only)</td>
<td>• Colorado Longitudinal Eating and Physical Activity (LEAP) study used screener in a white &amp; Hispanic low-income sample of caregivers of preschoolers.⁷¹ • Kolker et al. (2007): used in a sample of low-income parents of African American children ages 3-5 years living in the Detroit, MI area.⁷⁴ Validation: • Mulasi-Pokhriyal et al. (2013): used in a sample of Hmong-American children ages 9-18, but found that it did not validly capture milk intake compared to a 24-hour recall.⁷³</td>
<td>• Sweetened (sugary) beverages • Milk</td>
</tr>
</tbody>
</table>

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⁷¹ Approximately 3rd grade reading level.
⁷² Mulasi-Pokhriyal et al. (2013).
⁷³ No other studies of validity for assessing beverage intake reported.
⁷⁴ Validation of the screener's validity for assessing milk intake.
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<tr>
<td>Beverage Intake Questionnaire for Hispanic Preschool-aged Children (BEVQ-PS)</td>
<td>See Lora et al. (2016).</td>
<td>Proxy reports on child’s (ages: 3-5 years) intake (frequency, portion size) of beverages during the past month.</td>
<td>3-5 minutes (^7)</td>
<td>Lora et al. (2016) report that mothers found the BEVQ-PS easy to understand, but that mothers preferred the questionnaire read aloud to them. Literacy level was not explicitly reported.</td>
<td>In mothers of preschool children (n = 109), correlations between BEVQ-PS and 4-day food diaries were significant for water, juice drinks, whole milk, and sweetened carbonated drinks, and total sugar-sweetened beverages but were not significant for fruit juice, reduced-fat milk, low-fat/fat-free milk, flavored milk, diet carbonated drinks, tea with or without artificial sweetener, sports drinks, and total beverage intake. (^7)</td>
<td>In mothers of preschool children (n = 109), 1-week test-retest reliability was significant for all beverage categories except tea with or without artificial sweetener and flavored milk. Test-retest reliability was also significant for total sugar-sweetened beverages and total beverage grams and calories. (^7)</td>
<td>• English • Spanish</td>
<td>Validation: • Validity and reliability assessed among low-income Hispanic mothers. (^7)</td>
<td>• Water • 100% fruit juice • Sweetened juice beverage/fruit drink • Whole milk • Reduced fat milk • Low fat/fat-free milk • Flavored milk • Sweetened carbonated drinks or soda • Diet carbonated drinks, diet soda, or artificially sweetened drinks • Tea with or without artificial sweetener • Sports drinks • Total sugar-sweetened beverages • Total beverages</td>
</tr>
<tr>
<td>Healthy Children, Healthy Family Behavior Checklist (HCHF-BC)</td>
<td>Developed by Dickin et al. (2012) to evaluate a behavioral intervention for children in New York State.</td>
<td>Proxy reports on child’s (ages: 3-11 years) usual consumption (frequency) of soda.</td>
<td>5-10 minutes for full questionnaire. (^7)</td>
<td>Field testing and cognitive interviewing conducted to ensure understanding, but literacy level not explicitly reported. (^7)</td>
<td>Among parents (n = 66) across New York state, the soda item on the HCHF-BC correlated significantly with the Food Behavior Checklist (^7) and with the Child Food Frequency Questionnaire. (^7)</td>
<td>In a sample of primarily white parents (n = 38), 2-week test-retest reliability averaged 0.83 across all items on the checklist (reliability of soda item not reported separately). (^7)</td>
<td>• English • Spanish</td>
<td>Use: • Field tested in a diverse sample (two-thirds non-White). (^7) Validation: • Validity assessed in diverse sample (27% Latino, 30% African American). (^7)</td>
<td>• Soda</td>
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<td>Parent questionnaires for the Early Childhood Longitudinal Study Birth Cohort and Kindergarten Cohort</td>
<td>Questionnaires vary by wave. Instruments available here: <a href="https://nces.ed.gov/ecls/birthinstruments.asp">https://nces.ed.gov/ecls/birthinstruments.asp</a> and here: <a href="https://nces.ed.gov/ecls/kindergarten.asp">https://nces.ed.gov/ecls/kindergarten.asp</a></td>
<td>Proxy report of children’s (grades: preschool, kindergarten) frequency of consuming beverages (3 items) during the past 7 days.</td>
<td>&lt;5 minutes</td>
<td>Not reported</td>
<td>Not reported</td>
<td>Not reported</td>
<td>English</td>
<td>Developed for use in nationally representative samples that would include minorities and low-income households.</td>
<td>Milk (frequency and type) 100% juice Soda, sports drinks, or fruit drinks</td>
</tr>
<tr>
<td>EMPOWER questionnaire</td>
<td>See Knowlden (2015a and 2015b)</td>
<td>Proxy reports on child’s (ages: 4-6 years) consumption (total glasses) of sugar-free beverages ‘yesterday.’</td>
<td>Not reported</td>
<td>Not reported</td>
<td>Not reported</td>
<td>2-week test-retest reliability correlation coefficient of 0.71 for child’s consumption of sugar-free beverages.</td>
<td>English</td>
<td>None reported</td>
<td>Sugar-free beverages</td>
</tr>
<tr>
<td>Iowa Fluoride Study Targeted Nutrient Questionnaire</td>
<td>See Marshall et al. (2008),81</td>
<td>Proxy reports (with child input as appropriate) on child’s (ages: ~8-9 years) consumption (any consumption, number of servings) during the past week of foods and beverages related to bone health.</td>
<td>Not reported</td>
<td>Not reported</td>
<td>In a primarily white sample (n = 223), correlation coefficients with 3-day food diaries completed 4 to 9 months before the questionnaire were statistically significant for all beverage categories (range: 0.252 to 0.572).</td>
<td>Not reported</td>
<td>English</td>
<td>None reported</td>
<td>Total milk 100% juice Juice drinks Soda Water</td>
</tr>
<tr>
<td>Food Behavior Checklist Modified for Children (FBC-MC)</td>
<td>Branscum et al. (2010)82 describes the development of the checklist and gives sample items.</td>
<td>Children (ages: 8-10 years) self-report consumption of 14 food and beverage categories (yes/no)</td>
<td>&lt;5 minutes</td>
<td>Not reported</td>
<td>Experts assessed face validity and construct validity; criterion-related validity not reported.</td>
<td>Not reported</td>
<td>English</td>
<td>Branscum et al. (2010) developed the checklist for use in a low-income, majority-minority sample.82</td>
<td>Milk Sugar-sweetened beverages</td>
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<tr>
<td>Block Questionnaire for Ages 8-17</td>
<td>Available from Nutrition-Quest.</td>
<td>Children (ages: 8-17 years) self-report their usual intake (frequency, portion size) of 77 items over the previous six months.</td>
<td>Approximately 25 minutes to complete the full questionnaire</td>
<td>Not reported</td>
<td>One study found good correlations between the questionnaire and a 3-day diary in children ages 6-10 years for milk, 100% juice, fruit drinks, and soda. Another study found that correlation with 24-hour recall was lower, only 0.11, for assessing intake of 100% juice in children 10-17 years.</td>
<td>Adequate reliability for assessing intake of 100% juice in children 10-17 years.</td>
<td>English, Spanish</td>
<td>Use: - Smith and Fila used a Native American sample. - Wright (2015) used in a diverse sample in the Boston area. - Detroit Dental Health Project used with low-income African American children ages 0-5 years. - Texas Childhood Obesity Research Demonstration Study (TX-CORD) used Hispanic Block Questionnaire in a diverse sample of children ages 2-12 years.</td>
<td>Milk, 100% juice, Fruit drinks, Soda</td>
</tr>
<tr>
<td>4th grade version, School Physical Activity and Nutrition (SPAN) Survey</td>
<td>The full SPAN questionnaire can be found here: [<a href="https://sp.h">https://sp.h</a>. ee/research/ce nter/dell/proje ct.htm?project= 3037edaa-201e- 492b-b42f- f0208ccf8b29](<a href="https://sp.h">https://sp.h</a>. ee/research/ce nter/dell/proje ct.htm?project= 3037edaa-201e- 492b-b42f- f0208ccf8b29)</td>
<td>Children (grades: 4th) self-report their frequency of consumption of foods and beverages 'yesterday.' Does not assess portion size.</td>
<td>20-45 minutes to administer the all SPAN items; beverage questions ≤5 minutes.</td>
<td>Estimated to have a 4th grade reading level.</td>
<td>In fourth-graders, SPAN responses correlate adequately with 24-hour recall for sodas/soft drinks, 100% fruit juice, fruit-flavored drinks and sports drinks, and milk (correlation coefficients all 0.41-0.56).</td>
<td>2-hour test-retest reliability was good for the two beverage categories assessed (milk, fruit juice) in a sample of 9- and 10-year-old students.</td>
<td>English, Spanish</td>
<td>Use: - Evans et al. (2016) used SPAN items in a primarily minority and low-income sample. - Developed for use in schools across Texas which would include minority and low-income participants. Also used in the Massachusetts Childhood Obesity Research Demonstration (CORD) study, focused on low-income communities. Validation: - Reliability and validity assessed in two diverse samples.</td>
<td>Milk (including milk on cereal and drinks made with milk), Fruit juice, Fruit-flavored drinks or sports drinks, Regular soda, Diet soda</td>
</tr>
</tbody>
</table>

**References:**
- Smith and Fila (2008)
- Wright (2015)
- Detroit Dental Health Project (2015)
- Texas Childhood Obesity Research Demonstration Study (2015)
- Massachusetts Childhood Obesity Research Demonstration (CORD) study (2015)
- Evans et al. (2016)
- Massachusetts Childhood Obesity Research Demonstration (CORD) study (2015)
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| Food, Health, Choices Questionnaire (FHC-Q) | Developed by Gray et al. (2016) for use with 4th- and 5th-graders in New York City public schools. | Children (grades: 4th and 5th) self-report on their energy-balance-related behaviors, including consumption (frequency, portion size) of sugar-sweetened beverages during the past week. | Not reported     | Cognitive tests conducted to ensure understanding, but literacy level not explicitly reported. | Correlation coefficients in elementary school students (n=66) between the FHC-Q and the Beverage and Snack Questionnaire were significant for fruit drinks, sodas, sports drinks, and flavored water (range: 0.26-0.72). | 2-week test-retest reliability in elementary school students (n=155) for combined sugar-sweetened beverage items was high (range: 0.77-0.86, depending on mode of administration). | English | Validation:  
  • Validity and reliability assessed in schools that were primarily minority (27% African American, 69% Hispanic) and low-income (98% eligible for free or reduced price lunch).  
 Use:  
  • The YAQ was used by Project Eating Among Teens (EAT), which followed a racially and economically diverse sample of teens attending school in the Minneapolis/St. Paul, MN area.  
  • Elder et al. used beverage items from the YAQ in the Muevo study of children 5-8 years, 41% of whom were Latino  
 Validation:  
  • Cullen and Zakeri found good reliability but only modest validity in a sample of African American and Hispanic middle school students. | Fruit drinks or sweetened iced teas |
| Youth Adolescent Food Frequency Questionnaire (YAQ) | Documents for administering the YAQ can be found here: https://regepi.bwh.harvard.edu/health | Assesses child’s (ages: 9-17 years) consumption (frequency, portion size) of foods and beverages over the past year. | 20-30 minutes for full YAQ | Good validity against 24-hour recall for assessing energy and nutrient intakes in a sample of mostly white/Caucasian 9-17 years. A study of African American and Hispanic middle school students found lower validity vs. diaries for energy, fat, fruit, juice, and vegetables (no other beverage categories assessed). | Rockett and colleagues report 1-year test-retest correlation of 0.57 for soda and 0.56 for milk. In a sample of African American and Hispanic middle school students, Cullen and Zakeri report 3-week test-retest correlation of 0.37 for juice. | | English; see Elder (2014) for use in a Spanish-speaking population | Diet soda  
  • Soda (non-diet)  
  • Sweetened tea and fruit drinks  
  • Sports drinks  
  • Sugar-free or low-calorie energy drinks  
  • Regular energy drinks  
  • Smoothies  
  • Milkshakes  
  • Hot tea with caffeine  
  • Decaffeinated coffee  
  • Regular coffee  
  • Coffee drinks (with nonfat or whole milk; iced)  
  • Water  
  • Beer  
  • Wine or wine coolers  
  • Liquor |
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<td>Child questionnaires for the Early Childhood Longitudinal Study Kindergarten Cohort</td>
<td>Questions about beverage intake are similar in both the 5th and 8th grade surveys, and can be found here: <a href="https://nces.ed.gov/ecls/pdf/fifthgrade/childfoodconsumption.pdf">https://nces.ed.gov/ecls/pdf/fifthgrade/childfoodconsumption.pdf</a></td>
<td>Child (grades: 5th grade, 8th grade) self-reports frequency of consuming beverages (3 items) during past 7 days.</td>
<td>&lt;5 minutes</td>
<td>Not reported</td>
<td>Not reported</td>
<td>Not reported</td>
<td>English</td>
<td>Use: Developed for use in nationally representative samples that would include minorities and low-income households.</td>
<td>Milk (frequency and type) 100% juice Soda, sports drinks, or fruit drinks</td>
</tr>
<tr>
<td>5-a-Day Food Frequency Questionnaires</td>
<td>Items shown in Di Noia (2009).104</td>
<td>Children (ages: 10-14 years) self-report their usual intake (frequency) of fruit, juice, and vegetables during the past month</td>
<td>&lt;5 minutes</td>
<td>Not reported</td>
<td>Juice intake as reported on the questionnaire was weakly but not significantly correlated with direct observations of intake during a summer camp meal (r= 0.15 and p &gt; 0.05). Participants underestimated their intake on the questionnaire compared to observations.104</td>
<td>Not reported</td>
<td>English</td>
<td>Validation: Validity assessed among African American adolescents, but note that correlation between questionnaire and observation was low and not significant.104</td>
<td>100% fruit juice</td>
</tr>
<tr>
<td>SEARCH FFQ for children with type 1 diabetes</td>
<td>Questionnaire described by Liese et al. (2015).105</td>
<td>Adapted from the Block FFQ for youth with type 1 diabetes. Children (ages 10-24) self-report consumption (frequency, portion size) during past week.</td>
<td>Not reported</td>
<td>Not reported</td>
<td>Good validity for assessing sugar-sweetened beverage and fruit drink intake against 24-hour recall in 10-24 year olds with type 1 diabetes.105</td>
<td>Good 1-month test-retest reliability for assessing sugar-sweetened beverage and fruit drinks intake against 24-hour recall in 10-24 year olds with type 1 diabetes.105</td>
<td>English</td>
<td>Use: SEARCH study in which the FFQ was fielded included a sample that was about 27% non-White.106 Validation: Validation conducted in a sample with 15% African American and 11% other minority children.105</td>
<td>Sugar-sweetened beverages and fruit-flavored drinks</td>
</tr>
</tbody>
</table>
### Measuring Beverage Intake in Children and Adolescents

<table>
<thead>
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<tbody>
<tr>
<td>Screener to assess fast food and beverage intake in adolescents</td>
<td>Items can be found in Nelson &amp; Lytle (2009).</td>
<td>Adolescents (ages: 11-18 years) self-report consumption of beverages during past month. Assess frequency for: regular soda, diet soda, sports drinks, other sweetened beverages, milk, and coffee drinks. Assess amount for: regular soda, diet soda, and water.</td>
<td>&lt;10 minutes</td>
<td>Not reported</td>
<td>Nelson and Lytle validated against three 24-hour recalls in primarily white adolescents. Correlation coefficients frequency of consumption of regular soft drinks, sports drinks, and milk were significant; range: 0.25-0.38. Correlation for other sweetened beverages was 0.11 (p = 0.11). Validity could not be assessed for diet soft drinks or coffee drinks. Correlations for amount of regular soft drinks and water consumed were significant (range 0.19-0.20). Others examined validity in a sample of 35 female Latinas aged 14-17 years in East Los Angeles, CA. Compared to 3-day diet records, kappa statistics (κ’s) for individual beverage categories ranged from 0.01 to 0.18; none were significant.</td>
<td>• In a primarily white sample, Nelson &amp; Lytle report 1- to 2-week test-retest reliability correlation coefficients for frequency of beverage consumption were significant for all beverage categories (range: 0.63-0.84). Kappa statistics or amount of regular soft drink, diet soft drink, and water consumption were significant (range: 0.59-0.73). • In 35 Latina adolescents, 1-week test-retest reliability correlation coefficients for frequency of consumption of regular soda, diet soda, sports drinks, sweetened beverages, milk, and coffee drinks ranged from 0.53 to 0.71 (all p’s &lt; 0.05). Reliability for amount of regular soda, diet soda, and water consumed had κ’s between 0.44-0.61 (p’s &lt;0.01).</td>
<td>English</td>
<td>Validation: • Modified version of the screener was found to be reliable but not valid for assessing beverage intake in a sample of 35 Latina females ages 14-17 in East Los Angeles, CA.</td>
<td>• Regular soda • Diet soda • Sports drinks • Other sweetened beverages • Milk • Coffee drinks • Water</td>
</tr>
<tr>
<td>Single item for assessing milk consumption</td>
<td>Item is described by Mays (2011)</td>
<td>Adolescents and young adults (ages: 11-21 years) self-report on their frequency of milk consumption using a single item.</td>
<td>&lt;1 minute</td>
<td>Not reported</td>
<td>In a sample of survivors of childhood cancer ages 11-21 (n = 75), correlation coefficient between the milk item and total dietary calcium as assessed via a food frequency question was 0.31.</td>
<td>Not reported</td>
<td>• English</td>
<td>None reported</td>
<td>• Milk</td>
</tr>
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<tr>
<td><strong>10-item Food Frequency Questionnaire for assessing water intake</strong></td>
<td>Developed and used by Baranowski et al. (2010) to assess water intake in middle school students in 7 sites across the U.S.</td>
<td>Children (grades: middle school) self-report consumption of water (glasses) with breakfast, lunch, dinner, for a snack after school, and at other times, on school days vs. non-school days.</td>
<td>&lt;5 minutes</td>
<td>Cognitive interviewing suggested middle schoolers can understand items, but literacy level not explicitly reported.</td>
<td>In a sample of 6th grade students, mean intake of water reported on the FFQ was higher than reported in a 24-hour recall; no other validation information provided.</td>
<td>• English</td>
<td>• Development and validation occurred in a diverse sample of middle schoolers from 7 sites in the U.S.; ~50% Hispanic/Latino and ~25% African American.</td>
<td><strong>Water</strong></td>
<td></td>
</tr>
<tr>
<td><strong>EatWalk Survey</strong></td>
<td>Developed to evaluation an intervention for New York City middle school students. Items can be found in Contento (2010).</td>
<td>Children (grades: middle school) self-report their consumption (frequency, portion size) of water and sweetened beverages during the past week.</td>
<td>Not reported</td>
<td>Cognitive interviewing conducted to improve clarity, but literacy level not explicitly reported.</td>
<td>Contento and colleagues validated the EatWalk survey against the original Block instrument and against 24-hour recalls (n = 60). Agreement within 1 standard deviation ranged from 54% to 75%. Correlations between EatWalk responses and 24-hour recalls ranged from 0.30 to 0.60.</td>
<td>In a sample of 27 middle school students, test-retest reliability correlations ranged from 0.30-0.80 for all items on EatWalk survey, with most between 0.40-0.60 (reliability for beverage items not reported separately).</td>
<td>• English</td>
<td>• Used in a diverse, low-income sample of New York City middle school students (~ 25% African American, ~70% Latino, ~78% eligible for free or reduced price lunch).</td>
<td><strong>Water</strong></td>
</tr>
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<td></td>
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<td></td>
<td>Validation: Authors report that reliability and validity testing occurred in sample with diverse racial/ethnic backgrounds.</td>
<td></td>
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<td><strong>Sweetened beverages</strong></td>
</tr>
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| **Beverage and Snack Questionnaire (BSQ)** | Development is described by Neuhouser et al. (2012).59 Items can be found here: https://sharedresoures.fredhutch.org/sites/default/files/BSQ_QSample.pdf | Children (grades: middle school) self-report consumption (frequency only) of 19 items (9 beverages) at and away from school during past week. | <10 minutes      | Not reported | In a sample of 7th graders, Neuhouser et al. reported an average correlation coefficient of 0.70-0.71 between the BSQ and a 4-day diary for beverages (range 0.56-0.87).
Correlations with items on the School-Based Nutrition Monitoring Questionnaire (SBNMQ) were all statistically significant for items regarding consumption at home ($r = 0.12$-$0.30$, all $p$'s $< .05$) and at school ($r = .05$-$0.87$, all $p$'s $< .05$). | 0.70-0.71 | English | Use:  
• Johnson et al. (2009) used in a diverse sample of middle school students in Washington state.114  
• Chi et al. (2015) adapted for use in a Yup’ik Native Alaskans.115  
Validation:  
• Validation assessed in diverse sample of 7th grade students in Seattle, WA.91  
• Majumdar (2013) assess validity and reliability among African American and Hispanic students.113  
Modified version also assesses:  
• Water  
• Flavored milks  
• Sweetened coffee and tea drinks                                                                 | Original version assesses:  
• 100% juice  
• Fruit drinks  
• Sports drinks  
• Flavored waters  
• Regular soda  
• Diet soda  
• Energy drinks  
• 1% or nonfat milk  
• 2% or whole milk                                                                 |
| **Snack Foods Eaten at School and Home** | Described in Schwartz et al. (2009)116 | Children (grades: middle school) self-report consumption (frequency) of snack foods and beverages.116 | Not reported      | Not reported | Correlations with items on the School-Based Nutrition Monitoring Questionnaire (SBNMQ) were all statistically significant for items regarding consumption at home ($r = 0.12$-$0.30$, all $p$'s $< .05$) and at school ($r = .05$-$0.87$, all $p$'s $< .05$). | Not assessed | English | Use:  
• Schwartz et al. (2009)116 used in schools that were 50-63% white, 8-21% African American, ~24% Hispanic, 3-4% Asian, and ~1% American Indian. About one-third of students were eligible for free and reduced price lunch.                                                                 | 100% fruit juice                                                                 |
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<tr>
<td>Food frequency questionnaire to assess food behaviors of middle school students</td>
<td>Described by Wordell (2012)\textsuperscript{117}</td>
<td>Children (grades: middle school) self-report consumption (number of servings per day) of beverages in and outside of school during previous week.</td>
<td>5-7 minutes\textsuperscript{117}</td>
<td>Not reported</td>
<td>Not reported</td>
<td>Report that reliability was adequate (Cronbach's $\alpha$ range: 0.55 to 0.79) but do not provide further details on reliability testing (e.g., type of reliability assessed).\textsuperscript{117}</td>
<td>English</td>
<td>Use: * Wordell et al. (2012)\textsuperscript{117} fielded this instrument in six middle schools in the Midwest; schools were &gt;90% white and half had a large proportion (&gt;70%) of students eligible for free- and reduced price lunch.</td>
<td>100% fruit juice, Milk, Sweetened beverages, Energy drinks</td>
</tr>
<tr>
<td>California Health Interview Survey (CHIS), adolescent respondent</td>
<td>Full CHIS interview questions can be found here: <a href="http://healthpolicy.ucla.edu/chis/design/Pages/Questionnaires">http://healthpolicy.ucla.edu/chis/design/Pages/Questionnaires</a> (English) and here: <a href="http://healthpolicy.ucla.edu/chis/design/Pages/Questionnaires%20(Translated).aspx">http://healthpolicy.ucla.edu/chis/design/Pages/Questionnaires%20(Translated).aspx</a> (Translated)</td>
<td>Children (ages: 12-18 years) self-report consumption of beverages (number of bottles, cans) 'yesterday.'</td>
<td>Full survey ~20 minutes;\textsuperscript{45} beverage items should take &lt; 5 minutes</td>
<td>Not reported</td>
<td>Not reported</td>
<td>Not reported for beverage intake</td>
<td>English, Spanish, Cantonese, Mandarin, Korean, Vietnamese, Tagalog</td>
<td>Developed for use in large samples of Californians that would include minorities and low-income households.</td>
<td>Soda (non-diet), Sweetened fruit drinks, sports and energy drinks, Water</td>
</tr>
</tbody>
</table>
## Measuring Beverage Intake in Children and Adolescents

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<tbody>
<tr>
<td>Questionnaire to assess Soy Consumption</td>
<td>Described by Segovia-Siapco et al. (2014)</td>
<td>Children (ages: 12-18 years) self-report consumption (frequency) of soy-containing foods and beverages during the past 6 months.</td>
<td>Not reported</td>
<td>Segovia-Siapco et al. (2014) pilot-tested with adolescent girls to ensure participants could understand the items, but literacy level not explicitly reported.</td>
<td>In a subsample (n=70), average corrected correlation coefficient with 6 days of food diaries for intake of all soy-containing foods/beverages combined was 0.63 (p &gt; 0.05); correlation for beverages was not reported separately.</td>
<td>Not assessed</td>
<td>• English</td>
<td>• Soy beverages</td>
<td></td>
</tr>
</tbody>
</table>

### 8th-11th grade version, School Physical Activity and Nutrition (SPAN) Survey

The full SPAN questionnaire can be found here: [https://sph.uth.edu/research/centers/dell/projct.htm?project=3037edaa-201e-492a-b42f-f0208ccfbb29](https://sph.uth.edu/research/centers/dell/projct.htm?project=3037edaa-201e-492a-b42f-f0208ccfbb29)

Children (grades: 8th – 11th) self-report their frequency of consumption of foods and beverages ‘yesterday.’ Does not assess portion size. | 20-45 minutes to administer the entire SPAN questionnaire; beverage questions <5 minutes. | Estimates to have 5th grade reading level. | In eighth-graders, SPAN responses correlated well for milk and fruit juice (correlation coefficient = 0.68 and 0.40, respectively); other categories were not assessed. | Not assessed in this age group | • English, • Spanish | • Milk (including milk on cereal and drinks made with milk) |

### Validation:
- Validity and reliability of the 8th-11th grade questionnaire has also been established in a diverse population.
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<tbody>
<tr>
<td>National Youth Physical Activity and Nutrition Survey (NYPANS) items</td>
<td>Items described in O’Malley (2014)</td>
<td>Adolescents (grades: 9-12th) self-report consumption (frequency; amount for milk only) of 9 beverage items during the past week.</td>
<td>Not reported</td>
<td>Appropriate for high school students</td>
<td>In a sample of high school students (n=610), correlation coefficients between NYPANS items and repeated 24-hour recalls were statistically significant for water, juice, coffee/tea, diet soda, non-diet soda and other SSBs (correlations for sports drinks and energy drinks not assessed) and ranged from 0.26 to 0.49 with an average of 0.35 across all beverages.</td>
<td>Not assessed specifically for NYPANS, but Brener et al. report good 2-week test-retest reliability for similar items used in YRBSS.</td>
<td>English</td>
<td>Validation: - Validity assessed in a diverse sample (26% African American, 29% Hispanic, and 37% white). Developed for use in national survey, so meant to applicable to diverse populations.</td>
<td>- Plain water - 100% fruit juice - Coffee/tea - Diet soda - Non-diet soda - Other SSBs - Sports drinks - Energy drinks - Milk</td>
</tr>
<tr>
<td>High school survey, Youth Risk Behavior Surveillance Survey</td>
<td>Questionnaires can be found here: <a href="https://www.cdc.gov/healthyyouth/data/yrbs/questionnaires.htm">https://www.cdc.gov/healthyyouth/data/yrbs/questionnaires.htm</a></td>
<td>Adolescents (grades: 9-12th) self-report on consumption of beverages during previous 7 days. Questions about milk, soda, water, and sports drinks are semi-quantitative; juice question assesses frequency only.</td>
<td>&lt;5 minutes</td>
<td>Appropriate for high school students</td>
<td>None reported</td>
<td>Early studies suggest acceptable test-retest reliability over a 2-week period</td>
<td>English</td>
<td>Meant for population-based surveys that would include minorities and low-income participants.</td>
<td>- Soda (non-diet) - Milk (including milk on cereal) - Fruit juice - Plain water (national version) - Sports drinks (national version)</td>
</tr>
<tr>
<td>Snack and Beverage Food Frequency Questionnaire (SBFFQ)</td>
<td>Developed by Haire-Joshu et al. for use evaluating the effectiveness of an intervention among post-partum teenagers (average age: 17.8 years).</td>
<td>Adolescent (ages: ~17 years) self-reports consumption (frequency, usual portion size) of high calorie snacks and beverages during the past week.</td>
<td>Not reported</td>
<td>Not reported</td>
<td>Not reported</td>
<td>• 2-week test-retest reliability was high for sweetened beverages and water (ICCs = 0.68, 0.71, respectively).</td>
<td>English</td>
<td>Use: - Haire-Joshu (2015) used the SBFFQ in a sample with 52% minorities.</td>
<td>- Water - Sweetened beverages</td>
</tr>
</tbody>
</table>
III. State-of-the-Science: Measuring Beverage Intake in Children and Adolescents – Coming Soon

Introduction

In 2017, we conducted a systematic review of peer-reviewed studies assessing beverage intake in children and adolescents in the United States. The review covered 589 English-language studies published from February 2007 – February 2017, and addressed four key questions. In an online appendix to this report, to be released upon publication of the review, we will briefly describe findings related to each key question.

IV. Conclusions

Promoting healthy beverage intake, particularly among children and adolescents, has emerged in recent years as a policy and research priority. Because different dietary assessment methods are subject to specific and unique limitations that could influence study findings, it is important to understand what assessment methods are available, what properties they have, and what methods are typically used in the scientific literature. This report and our accompanying systematic review begin to address these issues. In general, we found that recent studies reflect the diversity of American children, and that a number of measurement techniques are available for assessing beverage intake in specific populations, such as those with lower-literacy, children of racial/ethnic minority backgrounds, and lower-income children. However, we also found that greater attention to issues of validity, reliability, and measurement error is warranted. Improved measurement techniques will help establish whether progress is being made toward ensuring that all children in the U.S. have healthy beverage consumption habits. Given the important role that beverage intake plays in range of children’s health and developmental outcomes, researchers and practitioners from a variety of areas should be invested in developing and applying thoughtful measurement techniques for assessing children’s beverage consumption.
References


MEASURING BEVERAGE INTAKE IN CHILDREN AND ADOLESCENTS


109. Mays D, Black JD, Mosher RB, Heinly A, Shad AT, Tercyak KP. Efficacy of the Survivor Health and Resilience Education (SHARE) program to improve bone health behaviors among
measuring beverage intake in children and adolescents


MEASURING BEVERAGE INTAKE IN CHILDREN AND ADOLESCENTS


