FirstLine Therapy Follow Up Questionnaire

Name_____ Date_____

1. At this point in the program, my primary goals and/or chief concerns are:

_____

_____

_____

_____

_____

_____

2. Assessment of your success with the FirstLine Therapy Program:

Balanced Eating:

I am eating from all of the 9 food categories found on the Menu Plan Worksheet:

☐Every day ☐75% of the time ☐50% of the time ☐25% of the time ☐Rarely

It is a challenge for me to eat regularly from the following food categories:

☐Protein ☐Category 1 Veggies ☐Category 2 Veggies ☐Dairy ☐Fruit
☐Grain ☐Legumes ☐Nuts & Seeds ☐Oil ☐No Problem

I eat other foods not found on the menu plan worksheet:

☐Every day ☐75% of the time ☐50% of the time ☐25% of the time ☐Rarely
List the foods:_____

_____

_____

I eat the recommended serving size for the foods in each category:

☐Every day ☐75% of the time ☐50% of the time ☐25% of the time ☐Rarely

I am challenged to stick to the serving size with the following food categories:

☐Protein ☐Category 1 Veggies ☐Category 2 Veggies ☐Dairy ☐Fruit
☐Grain ☐Legumes ☐Nuts & Seeds ☐Oil ☐No Problem
List the serving size you consume:_____

_____

I am consuming my medical food (UltraMeal drink or bar):

☐2 times per day... or ☐1 time per day... or ☐Never
...and my consistency level is:
☐Every day ☐75% of the time ☐50% of the time ☐25% of the time ☐Rarely

There is roughly a 3-hour interval between my meals (both meals and snacks):

☐Every day ☐75% of the time ☐50% of the time ☐25% of the time ☐Rarely

The most frequent problem with timing between meals occurs here (put a check):

Breakfast____AM snack____Lunch____PM Snack____Dinner____Evening Snack

I miss my (include an estimate of the percentage of the time you miss it):

☐Breakfast ☐AM snack ☐Lunch ☐PM Snack ☐Dinner ☐Evening Snack
_____% _____% ____% _____% ____% _____%

OVER

Reduce Stimulant Use:

I am currently using the following:

☐Cigarettes____# / day ☐Wine, Liquor, Beer:____# of servings / day
☐Coffee____# of cups / day ☐Tea____# of cups / day ☐Soft drinks____# / day

I am having candy, sweets, or dessert:

☐Daily ☐3-5 times per week ☐1-2 times per week ☐Other:_____
_____

Exercise:

I am currently doing aerobic exercise:

☐Daily ☐5 times per week ☐3 times per week ☐Other:_____
Type of exercise:_____

I am currently doing resistance (strength building) exercise:

☐Daily ☐5 times per week ☐3 times per week ☐Other:_____
Type of exercise:_____

I am currently following a stretching routine (to improve flexibility):

☐Daily ☐5 times per week ☐3 times per week ☐Other:_____

Stress Management:

I am getting at least 20 minutes of relaxation each day: ☐Yes ☐No
Type of relaxation:_____

I am currently getting a restful nights sleep: ☐Yes ☐No
If no, how many hours of sleep are you getting each night?_____

If you answered no to either of the questions above, **have you read the Stress Management chapter in the FirstLine Therapy Guidebook?** ☐Yes ☐No
If no, please read it and commit to applying its suggestions

Supplement Use:

I am taking my nutritional supplements and complying with the supplement schedule:

☐Every day ☐75% of the time ☐50% of the time ☐25% of the time ☐Rarely

3. Comments and challenges with the FirstLine Therapy Program:

I am having a challenge with the FirstLine Therapy Program: ☐Yes ☐No
If yes, is the challenge due to: ☐Lack of knowledge ☐Lack of discipline

What is the nature of your challenge?_____
_____
_____

Which of the following components would you like to re-evaluate:

☐Balanced eating ☐Exercise ☐Stress management ☐Supplement use

My attitude toward the FirstLine Therapy Program is:

☐Enthusiastic ☐Satisfied ☐Less than satisfied

4. Additional Comments_____
_____
_____
_____

FirstLine Therapy Health Profile

NAME _____ DATE _____ WEEK _____

Rate each of the following symptoms based upon your typical health profile for: ☐ *Past 30 days* ☐ *Past 48 hours*

Point Scale			
	0	*Never* or *almost never* have the symptom	3 *Frequently* have it, effect is *not severe*
	1	*Occasionally* have it, effect is *not severe*	4 *Frequently* have it, effect is *severe*
	2	*Ocasionally* have it, effect is *severe*	

HEAD
_____ Headaches
_____ Faintness
_____ Dizziness
_____ Insomnia
_____ TOTAL

EYES
_____ Watery or itchy eyes
_____ Swollen, reddened or sticky eyelids
_____ Bags or dark circles under eyes
_____ Blurred or tunnel vision (does not include near- or far-sightedness)
_____ TOTAL

EARS
_____ Itchy ears
_____ Earaches, ear infections
_____ Drainage from ear
_____ Ringing in ears, hearing loss
_____ TOTAL

NOSE
_____ Stuffy nose
_____ Sinus problems
_____ Hay fever
_____ Sneezing attacks
_____ Excessive mucus formation
_____ TOTAL

MOUTH/ THROAT
_____ Chronic coughing
_____ Gagging, frequent need to clear throat
_____ Sore throat, hoarseness, loss of voice
_____ Swollen or discolored tongue, gums or lips
_____ Canker sores
_____ TOTAL

SKIN
_____ Acne
_____ Hives, rashes, dry skin
_____ Hair loss
_____ Flushing, hot flashes
_____ Excessive sweating
_____ TOTAL

HEART
_____ Irregular or skipped heartbeat
_____ Rapid or pounding heartbeat
_____ Chest pain
_____ TOTAL

LUNGS
_____ Chest congestion
_____ Asthma, bronchitis
_____ Shortness of breath
_____ Difficulty breathing
_____ TOTAL

DIGESTIVE TRACT
_____ Nausea, vomiting
_____ Diarrhea
_____ Constipation
_____ Bloated feeling
_____ Belching, passing gas
_____ Heartburn
_____ Intestinal/stomach pain
_____ TOTAL

JOINTS / MUSCLE
_____ Pain or aches in joints
_____ Arthritis
_____ Stiffness or limitation of movement
_____ Pain or aches in muscles
_____ Feeling of weakness or tiredness
_____ TOTAL

WEIGHT
_____ Binge eating/drinking
_____ Craving certain foods
_____ Excessive weight
_____ Compulsive eating
_____ Water retention
_____ Underweight
_____ TOTAL

ENERGY / ACTIVITY
_____ Fatigue, sluggishness
_____ Apathy, lethargy
_____ Hyperactivity
_____ Restlessness
_____ TOTAL

MIND
_____ Poor memory
_____ Confusion, poor comprehension
_____ Poor concentration
_____ Poor physical coordination
_____ Difficulty in making decisions
_____ Stuttering or stammering
_____ Slurred speech
_____ Learning disabilities
_____ TOTAL

EMOTIONS
_____ Mood swings
_____ Anxiety, fear, nervousness
_____ Anger, irritability, aggressiveness
_____ Depression
_____ TOTAL

OTHER
_____ Frequent illness
_____ Frequent or urgent urination
_____ Genital itch or discharge
_____ TOTAL

GRAND TOTAL _____