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**_____
_____
_____