

FirstLineTherapy® 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
