

# FirstLineTherapy® Follow Up Questionnaire

Name \_\_\_\_\_ Date \_\_\_\_\_

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

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## 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: \_\_\_\_\_
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**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** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

