

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 FirstLine Therapy 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 vegetables Category 2 vegetables Dairy Fruit
- Grain Legumes Nuts and seeds Oil No problems

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

It is a challenge for me to stick to the serving size with the following food categories:

- Protein Category 1 vegetables Category 2 vegetables Dairy Fruit
- Grain Legumes Nuts and seeds Oil No problems

List the serving size you consume: _____

I am consuming my medical food (UltraMeal® Plus 360° drink or bar):

- 2 times per day 1 time per day 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 (place a check mark):

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
- _____ % _____ % _____ % _____ % _____ % _____ %

Stimulant use:

I am currently using the following:

- Cigarettes _____#/day Beer _____# svgs/day Wine _____# svgs/day Liquor _____# svgs/day
- Coffee _____# cups/day Tea _____# cups/day Soft drinks _____# cups

I am having candy, sweets, or dessert:

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

Exercise:

I am currently engaging in aerobic exercise:

- Daily 5 times per week 3 times per week Other _____

Type of exercise _____

I am currently engaging in 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 night's 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 the 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: _____
