TURACK CHIROPRACTIC
AND PERFORMANCE HEALTH

10850 PERRY HIGHWAY
WEXFORD, PA 15090
724.940.3499

Functional Medicine Intake Form

PLEASE COMPLETE THE INTAKE FORM AND THE 7 DAY NUTRITION AND LIFESTYLE JOURNAL AT LEAST 2 DAYS PRIOR TO YOUR SCHEDULED APPOINTMENT

PLEASE INCLUDE ANY RECENT BLOOD WORK OR OTHER PERTINENT TESTING

Name:

Date: Insurance:

Address:

City: State: Zip Code:

Home Phone: Cell Phone: Work Phone:

E-mail Address:

Age: Date of Birth: Gender: ▪ Male ▪ Female

Status:

- Married
- Widowed
- Separated
- Single
- Divorced
- Partnership

Live with:

- Spouse
- Children
- Partner
- Friends
- Parents
- Alone

Education:

Occupation: Hours per week: Retired

Employer	Work Address

In case of emergency, who should we contact?

Name	Relationship	Address	Phone

PLEASE SELECT THE SERVICES YOU ARE INTERESTED IN

☐ FUNCTIONAL MEDICINE	☐ NUTRITION AND LIFESTYLE COACHING	☐ DETOXIFICATION	☐ PERSONAL TRAINING
☐ FOOD SENSITIVITY TESTING	☐ WEIGHTLOSS PROGRAMS	☐ VITAMIN D THERAPY BED	☐ HIIT GROUP FITNESS
☐ HORMONE TESTING	☐ BODY COMPOSITION	☐ WHOLE BODY VIBRATION	☐ CHIROPRACTIC SERVICES
☐ LASER THERAPY	☐ BODY MOBILITY		

How did you hear about our Wellness and Nutrition Program?

_____
_____
_____
_____

What is your major complaint and when did the symptoms begin?

_____
_____
_____
_____
_____

What is your employment history? Please provide a brief summary

_____
_____
_____
_____

Please explain your housing history (type of homes, where and when)

_____
_____
_____
_____
_____
_____
_____

PRESCRIBED MEDICATIONS:

MEDICATION	DOSE	REASON FOR TAKING

SUPPLEMENTS AND VITAMINS:

SUPPLEMENT	DOSE	REASON FOR TAKING

ALLERGIES: (Please check all that apply)

☐ ADHESIVES	☐ ANIMALS (DANDER)	☐ ASPIRIN /OTHER PAIN MEDICINE
☐ BEE STINGS	☐ CEFFTIN	☐ CHOCOLATE
☐ DAIRY PRODUCTS	☐ DUST	☐ EGGS
☐ FLAX/LINSEED	☐ KIM/CLOVES	☐ LATEX
☐ MOLDS	☐ OXYCOTIN/CODEINE	☐ PEANUTS
☐ PENICILLIN	☐ POLLEN/RAGWEED	☐ RUBBER
☐ SEASONAL ALLERGIES	☐ SHELLFISH	☐ SOAPS/CLEANERS
☐ WHEAT	☐ X-RAY DYE	☐ OTHER

PAST OR CURRENT MEDICAL CONDITIONS: (Please check all that apply)

☐ ATTENTION DEFICIT DISORDER	☐ CHICKEN POX/SHINGLES	☐ HEADACHE	☐ MIGRAINES
☐ ALCOHOL DISORDER	☐ DIABETES MELLITUS	☐ FAINTING	☐ OSTEOPOROSIS
☐ ANEMIA	☐ DIZZINESS/VERTIGO	☐ HERPES	☐ PNEUMONIA
☐ ASTHMA	☐ DEPRESSION	☐ HIV	☐ RHEUMATOID ARTHRITIS
☐ APPENDICITIS	☐ EATING DISORDERS	☐ HEART DISEASE	☐ SEIZURE DISORDER
☐ ARTHRITIS	☐ EYE/VISION PROBLEMS	☐ HIGH BLOOD PRESSURE	☐ SLEEP APNEA
☐ BROKEN BONES	☐ EPILEPSY	☐ HODGKIN'S DISEASE	☐ SIBO
☐ BLEEDING DISORDER	☐ ECZEMA	☐ HASHIMOTO'S DISEASE	☐ SPINAL CORD INJURY
☐ BRONCHITIS	☐ EMPHYSEMA	☐ INSOMNIA	☐ THYROID DISORDER
☐ BACK PAIN	☐ ESOPHAGEAL REFLUX	☐ JOINT PAINT	☐ STROKE
☐ CANCER	☐ FATIGUE	☐ LYME DIES	☐ ULCERS
☐ CONCUSSION	☐ GASTROINTESTINAL DISORDER	☐ LUPUS	☐ URINARY TRACT INFECTIONS
☐ CARDIOVASCULAR DISEAE	☐ GLAUCOMA	☐ LEUKEMIA	☐ YEAST INFECTIONS

PAST SURGICAL HISTORY: (Please check all that apply)

☐ APPENDECTOMY	☐ HERNIA REPAIR	☐ PINCHED NERVE
☐ BACK SURGERY	☐ HYSTERECTOMY	☐ STENT PLACEMENT
☐ BREAST SURGERY	☐ HIP SURGERY	☐ SHOULDER SURGERY
☐ CATARACT SURGERY	☐ KNEE SURGERY	☐ SINUS SURGERY
☐ C-SECTION	☐ KIDNEY	☐ THORACIC DISC
☐ CARPAL TUNNEL	☐ LAPAROSCOPY	☐ THYROID SURGERY
☐ CERVICAL DISC	☐ LUMBAR DISC	☐ TONSILLECTOMY
☐ EENT	☐ NECK	☐ VASECTOMY
☐ GALLBLADDER	☐ NEUROLOGICAL	☐ WISDOM TEETH
☐ GASTROINTESTINAL	☐ OBSTETRICAL	☐ OTHER
☐ GYNOLCOLOGICAL	☐ PACEMAKER PLACEMENT	☐ OTHER
☐ HEART	☐ PROSTATE SURGERY	☐ OTHER

Functional Medicine Laboratory Testing Informed Consent

The purpose of functional medicine laboratory testing in our office is to evaluate nutritional, biochemical, or physiological imbalance and to determine any need for medical referral. These lab tests in our office are not intended to diagnose disease. This office utilizes conventional lab tests as well as functional medicine assessment. Functional medicine assessment is designed to assist our doctors and other healthcare providers in finding the underlying causes of your condition. Functional medicine has evolved through the efforts of scientists and clinicians from the fields of clinical nutrition, molecular biology, biochemistry, physiology, conventional medicine, and a wide array of scientific disciplines. Functional medicine evaluates the body as a whole, with special attention to the relationship of one body system to another and the nutrient imbalances and toxic overload that may adversely affect these relationships.

Your medical physician may or may not agree with the necessity for—or our interpretation of—these tests. If you have any questions or concerns, please discuss them with our doctors.

Selling Nutritional and Herbal Supplements

According to the Federal Food, Drug, and Cosmetic Act, as amended, Section 201(g)(1), the term *drug* is defined as an "article intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease." Technically, vitamins, minerals, trace elements, amino acids, herbs, or homeopathic remedies are not classified as drugs. However, these substances can have significant effects on physiology and must be used rationally. In this office, we provide nutritional counseling and make individualized recommendations regarding use of these substances in order to upgrade the quality of foods in a patient's diet and to supply nutrition to support the physiological and biomechanical processes of the human body. Although these products may also be suggested with a specific therapeutic purpose in mind, their use is chiefly designed to support given aspects of metabolic function. Use of nutritional supplements may be safely recommended for patients already using pharmaceutical medications (drugs), but some potentially harmful interactions may occur. For this reason, it is important to keep all of your healthcare providers fully informed about all medications and nutritional supplements, herbs, or hormones you may be taking.

Sale of Nutritional Supplements at Turack Chiropractic and Performance Health

As a service to you, we make nutritional supplements available in our office. We purchase these products only from manufacturers who have gained our confidence through considerable research and experience. We determine quality by considering: (1) the quality of science behind the product; (2) the quality of the ingredients themselves; (3) the quality of the manufacturing process; and (4) the synergism among product components. The brands of supplements that we carry in our facility are those that meet our high standards and tend to produce predictable results.

While these supplements may come at a higher financial cost than those found on the shelves of pharmacies or health food stores, the value must also include assurance of their purity, quality, bioavailability (ability to be properly absorbed and utilized by the body), and effectiveness. The chief reason we make these products available is to ensure quality. You are not guaranteed the same level of quality when you purchase your supplements from the general marketplace. We are not suggesting that such products have no value; however, given the lack of stringent testing requirements for dietary supplements, product quality varies widely.

If you have concerns about this issue, please discuss them with our staff.

I, _____, have read and understand the above statement on _____ (date),
witnessed by_____, _____ (date).

Nutrition Cancellation and No-Show Policy

Our goal at Turack Chiropractic is to provide quality care in a timely manner. To respect the health needs of our other patients, please be courteous and call the office as soon as possible if you are unable to attend an appointment.

If it is necessary to cancel your scheduled appointment, we ask that you call at least 24 hours in advance. Appointments are in high demand and your early cancellation gives another person access to timely care.

We do understand that circumstances may arise which are outside of your control, and you will not be penalized for "late" cancellations due to emergencies. However habitually late cancelling or late rescheduling, may be subject to patient dismissal and is at the discretion of the doctor. Nutrition appointments are scheduled for 30 minutes to one hour. When these appointments are missed by the patient or rescheduled at the last minute, they are often hard to fill.

A no-show is someone who misses an appointment without notice. No-shows inconvenience those individuals who need access to care in a timely manner, as well as our providers. A failure to present at the time of a scheduled appointment will be recorded in the patient's chart as a no-show. You are responsible for 1/2 of the missed appointment fee. A 30 minute appointment will be charged at $50, a 1 hour appointment will be charged $100. If you have missed an appointment, you will be notified via phone and mail, and any further appointments will require a prepayment for the appointment. The patient will be sent a letter alerting them to the fact that they have failed to show up for an appointment and did not cancel the appointment one working day in advance. As with late cancelling, habitually no-showing may result in a suspension of services and is at the discretion of the doctor.

I understand the guidelines of Turack Chiropractic's cancellation and no-show policy.

Patient Signature_____Date_____

Witness_____Date_____

Medical Symptoms Questionnaire (MSQ)

Patient Name_____ Date_____

Rate each of the following symptoms based upon your typical health profile for the past 14 days.

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

MEDICAL SYMPTOMS QUESTIONNAIRE (MSQ)

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_____

Candida Screening Questionnaire

Answering these questions and adding up the scores will help you and your clinician decide if yeast may be contributing to your health problems.

For each section read the directions and score as indicated. Total your score and record it at the end of the section.
Add the totals for each section to get your Grand Total Score.

Section A: History

For each "yes" answer, circle the point score for that question. Add up the total score and record it at the end of this section.

section a: History		Point Score
1 Have you taken tetracyclines (Sumycin, Panmycino, Vibramycin, Minocin, etc.) or other antibiotics for acne for one month (or longer)?		35
2 Have you, at any time in your life, taken other "broad spectrum" antibiotics* for respiratory, urinary, or other infections (for two months or longer, or in shorter courses four or more times in a one-year period)?		35
3 Have you taken a broad spectrum antibiotic drug*, even a single course?		6
4 Have you, at any time in your life, been bothered by persistent prostatitis, vaginitis, or other problems affecting your reproductive organs?		25
5 Have you been pregnant?	*One time?*	3
	Two or more times?	5
6 Have you taken birth control pills?	*For six months to two years?*	8
	For more than two years?	15
7 Have you taken prednisone, decadron or other cortisone-type drugs?	*For two weeks or less?*	6
	For more than two weeks?	15
8 Does exposure to perfumes, insecticides, fabric shop odors, and other chemicals provoke symptoms?	*Mild symptoms?*	5
	Moderate to severe symptoms?	20
9 Are your symptoms worse on damp, muggy days or in moldy places?		20
10 Have you had athlete's foot, ringworm, "jock itch," or other chronic fungus infections of the skin or nails?	*Mild to moderate?*	10
	Severe or persistent?	20
11 Do you crave sugar?		10
12 Do you crave breads?		10
13 Do you crave alcoholic beverages?		10
14 Does tobacco smoke really bother you?		10
	Section A Total	_____

*Including Keflex, ampicillin, amoxicillin, Ceclor, Bactrim, and Septra. Such antibiotics kill off "good germs" while they're killing off those which cause infection.

Section B: Major Symptoms

For each of your symptoms, circle the appropriate figure in the point score column. Add up the total score and record it at the end of this section.

section b: Major Symptoms	Point Score		
	Occasional and/or Mild	*Frequent and/ or Moderately Severe*	*Very Frequent and/or Very Severe or Disabling*
1 Fatigue or lethargy	3	6	9
2 Feeling of being “drained”	3	6	9
3 Poor memory	3	6	9
4 Depression	3	6	9
5 Feeling “spacey” or “unreal”	3	6	9
6 Inability to make decisions	3	6	9
7 Numbness, burning, or tingling	3	6	9
8 Muscle aches or weakness	3	6	9
9 Pain and/or swelling in joints	3	6	9
10 Abdominal pain	3	6	9
11 Constipation	3	6	9
12 Diarrhea	3	6	9
13 Bloating, belching, or intestinal gas	3	6	9
14 Troublesome vaginal burning, itching, or discharge	3	6	9
15 Persistent vaginal burning or itching	3	6	9
16 Prostatitis	3	6	9
17 Impotence	3	6	9
18 Loss of sexual desire or feeling	3	6	9
19 Endometriosis or infertility	3	6	9
20 Cramps and/or other menstrual irregularities	3	6	9
21 Premenstrual tension	3	6	9
22 Attacks of anxiety or crying	3	6	9
23 Cold hands or feet and/or chilliness	3	6	9
24 Shaking or irritable when hungry	3	6	9
		Section B Total	_____

Section C: Other Symptoms*

For each of your symptoms, circle the appropriate figure in the point score column. Add up the total score and record it at the end of this section.

Section C: Other Symptoms	Point Score		
	Occasional and/or Mild	*Frequent and/ or Moderately Severe*	*Very Frequent and/or Very Severe or Disabling*
1 Drowsiness	1	2	3
2 Irritability or jitteriness	1	2	3
3 Uncoordination	1	2	3
4 Inability to concentrate	1	2	3
5 Frequent mood swings	1	2	3
6 Headache	1	2	3
7 Dizziness/loss of balance	1	2	3
8 Pressure above ears, feeling of head swelling	1	2	3
9 Tendency to bruise easily	1	2	3
10 Chronic rashes or itching	1	2	3
13 Numbness, tingling	1	2	3
13 Indigestion or heartburn	1	2	3
14 Food sensitivity or intolerance	1	2	3
14 Mucus in stools	1	2	3
15 Rectal itching	1	2	3
16 Dry mouth or throat	1	2	3
17 Rash or blisters in mouth	1	2	3
18 Bad breath	1	2	3
19 Foot, body, or hair odor not relieved by washing	1	2	3
20 Nasal congestion or postnasal drip	1	2	3
21 Nasal itching	1	2	3
22 Sore throat	1	2	3
23 Laryngitis, loss of voice	1	2	3
24 Cough or recurrent bronchitis	1	2	3
25 Pain or tightness in chest	1	2	3

*While the symptoms in this section commonly occur in people with yeast-connected illness, they are also found in other individuals

Section C: Other Symptoms	Point Score		
	Occasional and/or Mild	*Frequent and/ or Moderately Severe*	*Very Frequent and/or Very Severe or Disabling*
26 Wheezing or shortness of breath	1	2	3
27 Urgency or urinary frequency	1	2	3
28 Burning on urination	1	2	3
29 Spots in front of eyes or erratic vision	1	2	3
30 Burning or tearing of eyes	1	2	3
31 Recurrent infections or fluid in ears	1	2	3
32 Ear pain or deafness	1	2	3
		Section C Total	_____

Section A Total Score _____

Section B Total Score _____

Section C Total Score _____

Grand Total Score _____

The Grand Total Score will help you and your clinician decide if your health problems are yeast connected. Scores in women will run higher as seven items in the questionnaire apply exclusively to women, while only two apply exclusively to men.

Men	Women	Interpretation
40 or below	60 or below	Yeast is less apt to cause health problems
41-90	61-121	Yeast-connected health problems are possibly present
91-140	121-180	Yeast-connected health problems are probably present
141 or higher	181 or higher	Yeast-connected health problems are almost certainly present

Diet, Nutrition, and Lifestyle Journal – 7 Day

Patient Name_____ Date_____

Food Plan Type:_____

Day 1

Day Event	Food & Drink Intake (include type, amount, brand)	Macronutrients (PFC) and Phytonutrients
Rising Time		
Breakfast **Time**		_____ P_____F_ _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Mid-AM Snack **Time**		_____ P_____F_ _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Lunch **Time**		_____ P_____F_ _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Mid-PM Snack **Time**		_____ P_____F_ _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Dinner **Time**		_____ P_____F_ _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
PM Snack **Time**		_____ P_____F_ _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Bed Time		

***P**: Proteins; **F**: Fats; **C**: Carbohydrates; **R**: Red; **O**: Orange; **Y**: Yellow; **G**: Green; **B/P/BL**: Blue/Purple/Black; **W/T/BR**: White/Tan/Brown*

Sleep & Relaxation	Exercise & Movement	Stress	Relationships
Sleep Quantity: _____ (hours) Quality: ☐Poor ☐Fair ☐Good **Relaxation** ☐Yes ☐No Type/Amount:	Type, Duration, & Intensity ☐ Aerobic: ☐ Strength: ☐ Flexibility:	Stress Reduction Practices: Stressors:	Supporting: Non-supporting:

Mental	Emotional	Spiritual

Diet, Nutrition, and Lifestyle Journal – 7 Day

Patient Name_____ Date_____

Food Plan Type:_____

Day 2

Day Event	Food & Drink Intake (include type, amount, brand)	Macronutrients (PFC) and Phytonutrients
Rising Time		
Breakfast **Time**		_____ P_____F_ _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Mid-AM Snack **Time**		_____ P_____F_ _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Lunch **Time**		_____ P_____F_ _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Mid-PM Snack **Time**		_____ P_____F_ _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Dinner **Time**		_____ P_____F_ _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
PM Snack **Time**		_____ P_____F_ _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Bed Time		

***P**: Proteins; **F**: Fats; **C**: Carbohydrates; **R**: Red; **O**: Orange; **Y**: Yellow; **G**: Green; **B/P/BL**: Blue/Purple/Black; **W/T/BR**: White/Tan/Brown*

Sleep & Relaxation	Exercise & Movement	Stress	Relationships
Sleep Quantity: _____ (hours) Quality: ☐Poor ☐Fair ☐Good **Relaxation** ☐Yes ☐No Type/Amount:	Type, Duration, & Intensity ☐ Aerobic: ☐ Strength: ☐ Flexibility:	Stress Reduction Practices: Stressors:	Supporting: Non-supporting:

Mental	Emotional	Spiritual

Diet, Nutrition, and Lifestyle Journal – 7 Day

Patient Name_____ Date_____

Food Plan Type:_____

Day 3

Day Event	Food & Drink Intake (include type, amount, brand)	Macronutrients (PFC) and Phytonutrients
Rising Time		
Breakfast **Time**		_____ P_____F_ _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Mid-AM Snack **Time**		_____ P_____F_ _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Lunch **Time**		_____ P_____F_ _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Mid-PM Snack **Time**		_____ P_____F_ _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Dinner **Time**		_____ P_____F_ _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
PM Snack **Time**		_____ P_____F_ _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Bed Time		

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Sleep & Relaxation	Exercise & Movement	Stress	Relationships
Sleep Quantity: _____ (hours) Quality: ☐Poor ☐Fair ☐Good **Relaxation** ☐Yes ☐No Type/Amount:	Type, Duration, & Intensity ☐ Aerobic: ☐ Strength: ☐ Flexibility:	Stress Reduction Practices: Stressors:	Supporting: Non-supporting:

Mental	Emotional	Spiritual

Diet, Nutrition, and Lifestyle Journal – 7 Day

Patient Name_____ Date_____

Food Plan Type:_____

Day 4

Day Event	Food & Drink Intake (include type, amount, brand)	Macronutrients (PFC) and Phytonutrients
Rising Time		
Breakfast **Time**		_____ P_____F_ _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Mid-AM Snack **Time**		_____ P_____F_ _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Lunch **Time**		_____ P_____F_ _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Mid-PM Snack **Time**		_____ P_____F_ _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Dinner **Time**		_____ P_____F_ _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
PM Snack **Time**		_____ P_____F_ _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Bed Time		

***P**: Proteins; **F**: Fats; **C**: Carbohydrates; **R**: Red; **O**: Orange; **Y**: Yellow; **G**: Green; **B/P/BL**: Blue/Purple/Black; **W/T/BR**: White/Tan/Brown*

Sleep & Relaxation	Exercise & Movement	Stress	Relationships
Sleep Quantity: _____ (hours) Quality: ☐Poor ☐Fair ☐Good **Relaxation** ☐Yes ☐No Type/Amount:	Type, Duration, & Intensity ☐ Aerobic: ☐ Strength: ☐ Flexibility:	Stress Reduction Practices: Stressors:	Supporting: Non-supporting:

Mental	Emotional	Spiritual

Diet, Nutrition, and Lifestyle Journal – 7 Day

Patient Name_____ Date_____

Food Plan Type:_____

Day 5

Day Event	Food & Drink Intake (include type, amount, brand)	Macronutrients (PFC) and Phytonutrients
Rising Time		
Breakfast **Time**		_____ P_____F_ _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Mid-AM Snack **Time**		_____ P_____F_ _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Lunch **Time**		_____ P_____F_ _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Mid-PM Snack **Time**		_____ P_____F_ _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Dinner **Time**		_____ P_____F_ _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
PM Snack **Time**		_____ P_____F_ _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Bed Time		

***P**: Proteins; **F**: Fats; **C**: Carbohydrates; **R**: Red; **O**: Orange; **Y**: Yellow; **G**: Green; **B/P/BL**: Blue/Purple/Black; **W/T/BR**: White/Tan/Brown*

Sleep & Relaxation	Exercise & Movement	Stress	Relationships
Sleep Quantity: _____ (hours) Quality: ☐Poor ☐Fair ☐Good **Relaxation** ☐Yes ☐No Type/Amount:	Type, Duration, & Intensity ☐ Aerobic: ☐ Strength: ☐ Flexibility:	Stress Reduction Practices: Stressors:	Supporting: Non-supporting:

Mental	Emotional	Spiritual

Diet, Nutrition, and Lifestyle Journal – 7 Day

Patient Name_____ Date_____

Food Plan Type:_____

Day 6

Day Event	Food & Drink Intake (include type, amount, brand)	Macronutrients (PFC) and Phytonutrients
Rising Time		
Breakfast **Time**		_____ P_____F_ _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Mid-AM Snack **Time**		_____ P_____F_ _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Lunch **Time**		_____ P_____F_ _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Mid-PM Snack **Time**		_____ P_____F_ _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Dinner **Time**		_____ P_____F_ _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
PM Snack **Time**		_____ P_____F_ _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Bed Time		

***P**: Proteins; **F**: Fats; **C**: Carbohydrates; **R**: Red; **O**: Orange; **Y**: Yellow; **G**: Green; **B/P/BL**: Blue/Purple/Black; **W/T/BR**: White/Tan/Brown*

Sleep & Relaxation	Exercise & Movement	Stress	Relationships
Sleep Quantity: _____ (hours) Quality: ☐Poor ☐Fair ☐Good **Relaxation** ☐Yes ☐No Type/Amount:	Type, Duration, & Intensity ☐ Aerobic: ☐ Strength: ☐ Flexibility:	Stress Reduction Practices: Stressors:	Supporting: Non-supporting:

Mental	Emotional	Spiritual

Diet, Nutrition, and Lifestyle Journal – 7 Day

Patient Name_____ Date_____

Food Plan Type:_____

Day 7

Day Event	Food & Drink Intake (include type, amount, brand)	Macronutrients (PFC) and Phytonutrients
Rising Time		
Breakfast **Time**		_____ P_____ F_ _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Mid-AM Snack **Time**		_____ P_____ F_ _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Lunch **Time**		_____ P_____ F_ _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Mid-PM Snack **Time**		_____ P_____ F_ _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Dinner **Time**		_____ P_____ F_ _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
PM Snack **Time**		_____ P_____ F_ _____ C ☐ R ☐ O ☐ Y ☐ G ☐ B/P/BL ☐ W/T/BR
Bed Time		

***P**: Proteins; **F**: Fats; **C**: Carbohydrates; **R**: Red; **O**: Orange; **Y**: Yellow; **G**: Green; **B/P/BL**: Blue/Purple/Black; **W/T/BR**: White/Tan/Brown*

Sleep & Relaxation	Exercise & Movement	Stress	Relationships
Sleep Quantity: _____ (hours) Quality: ☐Poor ☐Fair ☐Good **Relaxation** ☐Yes ☐No Type/Amount:	Type, Duration, & Intensity ☐ Aerobic: ☐ Strength: ☐ Flexibility:	Stress Reduction Practices: Stressors:	Supporting: Non-supporting:

Mental	Emotional	Spiritual

Daily Activity Questionnaire

Patient Name_____ Date_____

Please check the one best response for each activity described below:

SEDENTARY BEHAVIOR

Sitting while watching TV, at a computer, driving, talking on the phone, or reading

- ☐ 1 Most of the day
- ☐ 2 Half of the day
- ☐ 3 Some of the day
- ☐ 4 Rarely

Total_____

ACTIVITIES OF DAILY LIVING

Bathing, dressing, feeding self, toilet

- ☐ 1 Need some assistance
- ☐ 2 Slight difficulty
- ☐ 3 Minimal difficulty
- ☐ 4 No problem

Total_____

Laundry

- ☐ 1 Unable
- ☐ 2 Occasionally
- ☐ 3 Regularly in small steps or with help
- ☐ 4 Regularly without help

Total_____

Cooking

- ☐ 1 Unable
- ☐ 2 Take-out, breakfast, or simple lunch only
- ☐ 3 Simple microwave or crockpot meal
- ☐ 4 Regular meals

Total_____

Housekeeping

- ☐ 1 Unable
- ☐ 2 Light dusting, straighten up
- ☐ 3 Regular housekeeping in small steps or with help
- ☐ 4 Fully capable

Total_____

Grocery Shopping

- ☐ 1 Unable
- ☐ 2 Occasional (once or twice per month)
- ☐ 3 Frequent, but with assistance
- ☐ 4 No problem

Total_____

Social Activities

Church, temple, family and friends

- ☐ 1 Unable
- ☐ 2 Infrequently
- ☐ 3 Occasionally (once or twice per month)
- ☐ 4 Frequently (weekly or more often)

Total_____

Driving

- ☐ 1 Unable
- ☐ 2 Very limited
- ☐ 3 Cautious, local trips
- ☐ 4 Distant trips or traffic

Total_____

Errands or Light Chores

Post office, drop off a child

- ☐ 1 None
- ☐ 2 0-1 per day
- ☐ 3 2-3 per day
- ☐ 4 No or few restrictions

Total_____

Grand Total_____