



## 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
- Separated
- Divorced

- Widowed
- Single
- Partnership

Live with:

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

Education:

Occupation:  Hours per week:   Retired

Employer  Work Address

In case of emergency, who should we contact?

Name	Relationship	Address	Phone
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**PLEASE SELECT THE SERVICES YOU ARE INTERESTED IN**

<input type="checkbox"/> FUNCTIONAL MEDICINE	<input type="checkbox"/> NUTRITION AND LIFESTYLE COACHING	<input type="checkbox"/> DETOXIFICATION	<input type="checkbox"/> PERSONAL TRAINING
<input type="checkbox"/> FOOD SENSITIVITY TESTING	<input type="checkbox"/> WEIGHTLOSS PROGRAMS	<input type="checkbox"/> VITAMIN D THERAPY BED	<input type="checkbox"/> HIIT GROUP FITNESS
<input type="checkbox"/> HORMONE TESTING	<input type="checkbox"/> BODY COMPOSITION	<input type="checkbox"/> WHOLE BODY VIBRATION	<input type="checkbox"/> CHIROPRACTIC SERVICES
<input type="checkbox"/> LASER THERAPY	<input type="checkbox"/> BODY MOBILITY		

**How did you hear about our Wellness and Nutrition Program?**

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

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**What is your employment history? Please provide a brief summary**

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

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**PRESCRIBED MEDICATIONS:**

MEDICATION	DOSE	REASON FOR TAKING

**SUPPLEMENTS AND VITAMINS:**

SUPPLEMENT	DOSE	REASON FOR TAKING

**ALLERGIES: (Please check all that apply)**

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

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

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

**PAST SURGICAL HISTORY: (Please check all that apply)**

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

## Functional Medicine Laboratory Testing Informed Consent

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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      3 – *Frequently* have it, effect is *not severe*  
1 – *Occasionally* have it, effect is *not severe*              4 – *Frequently* have it, effect is *severe*  
2 – *Occasionally* 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  
\_\_\_\_\_ Bloating 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?	<i>One time?</i> 3
		<i>Two or more times?</i> 5
6	Have you taken birth control pills?	<i>For six months to two years?</i> 8
		<i>For more than two years?</i> 15
7	Have you taken prednisone, decadron or other cortisone-type drugs?	<i>For two weeks or less?</i> 6
		<i>For more than two weeks?</i> 15
8	Does exposure to perfumes, insecticides, fabric shop odors, and other chemicals provoke symptoms?	<i>Mild symptoms?</i> 5
		<i>Moderate to severe symptoms?</i> 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?	<i>Mild to moderate?</i> 10
		<i>Severe or persistent?</i> 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
<b>Section A Total</b>		_____

\*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		
	<i>Occasional and/or Mild</i>	<i>Frequent and/ or Moderately Severe</i>	<i>Very Frequent and/or Very Severe or Disabling</i>
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
	<b>Section B Total</b>		_____

## 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		
	<i>Occasional and/or Mild</i>	<i>Frequent and/ or Moderately Severe</i>	<i>Very Frequent and/or Very Severe or Disabling</i>
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		
	<i>Occasional and/or Mild</i>	<i>Frequent and/or Moderately Severe</i>	<i>Very Frequent and/or Very Severe or Disabling</i>
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
	<b>Section C Total</b>		_____

**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 <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Mid-AM Snack Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Lunch Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Mid-PM Snack Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Dinner Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
PM Snack Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> 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
<b>Sleep</b> Quantity: _____ (hours) Quality: <input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good <b>Relaxation</b> <input type="checkbox"/> Yes <input type="checkbox"/> No Type/Amount:	Type, Duration, & Intensity <input type="checkbox"/> Aerobic:  <input type="checkbox"/> Strength:  <input type="checkbox"/> 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 <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Mid-AM Snack Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Lunch Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Mid-PM Snack Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Dinner Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
PM Snack Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> 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
<b>Sleep</b> Quantity: _____ (hours) Quality: <input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good <b>Relaxation</b> <input type="checkbox"/> Yes <input type="checkbox"/> No Type/Amount:	Type, Duration, & Intensity <input type="checkbox"/> Aerobic:  <input type="checkbox"/> Strength:  <input type="checkbox"/> 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 <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Mid-AM Snack Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Lunch Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Mid-PM Snack Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Dinner Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
PM Snack Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> 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
<b>Sleep</b> Quantity: _____ (hours) Quality: <input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good  <b>Relaxation</b> <input type="checkbox"/> Yes <input type="checkbox"/> No Type/Amount:	Type, Duration, & Intensity <input type="checkbox"/> Aerobic:  <input type="checkbox"/> Strength:  <input type="checkbox"/> 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 <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Mid-AM Snack Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Lunch Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Mid-PM Snack Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Dinner Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
PM Snack Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> 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
<b>Sleep</b> Quantity: _____ (hours) Quality: <input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good  <b>Relaxation</b> <input type="checkbox"/> Yes <input type="checkbox"/> No Type/Amount:	Type, Duration, & Intensity <input type="checkbox"/> Aerobic:  <input type="checkbox"/> Strength:  <input type="checkbox"/> 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 <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Mid-AM Snack Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Lunch Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Mid-PM Snack Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Dinner Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
PM Snack Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> 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
<b>Sleep</b> Quantity: _____ (hours) Quality: <input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good <b>Relaxation</b> <input type="checkbox"/> Yes <input type="checkbox"/> No Type/Amount:	Type, Duration, & Intensity <input type="checkbox"/> Aerobic:  <input type="checkbox"/> Strength:  <input type="checkbox"/> 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 <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Mid-AM Snack Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Lunch Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Mid-PM Snack Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Dinner Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
PM Snack Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> 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
<b>Sleep</b> Quantity: _____ (hours) Quality: <input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good <b>Relaxation</b> <input type="checkbox"/> Yes <input type="checkbox"/> No Type/Amount:	Type, Duration, & Intensity <input type="checkbox"/> Aerobic:  <input type="checkbox"/> Strength:  <input type="checkbox"/> 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 <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Mid-AM Snack Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Lunch Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Mid-PM Snack Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Dinner Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
PM Snack Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> 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
<b>Sleep</b> Quantity: _____ (hours) Quality: <input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good <b>Relaxation</b> <input type="checkbox"/> Yes <input type="checkbox"/> No Type/Amount:	Type, Duration, & Intensity <input type="checkbox"/> Aerobic:  <input type="checkbox"/> Strength:  <input type="checkbox"/> 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:

<b>SEDENTARY BEHAVIOR</b> Sitting while watching TV, at a computer, driving, talking on the phone, or reading	<input type="checkbox"/> 1 Most of the day <input type="checkbox"/> 2 Half of the day <input type="checkbox"/> 3 Some of the day <input type="checkbox"/> 4 Rarely	Total _____
<b>ACTIVITIES OF DAILY LIVING</b> Bathing, dressing, feeding self, toilet	<input type="checkbox"/> 1 Need some assistance <input type="checkbox"/> 2 Slight difficulty <input type="checkbox"/> 3 Minimal difficulty <input type="checkbox"/> 4 No problem	Total _____
<b>Laundry</b>	<input type="checkbox"/> 1 Unable <input type="checkbox"/> 2 Occasionally <input type="checkbox"/> 3 Regularly in small steps or with help <input type="checkbox"/> 4 Regularly without help	Total _____
<b>Cooking</b>	<input type="checkbox"/> 1 Unable <input type="checkbox"/> 2 Take-out, breakfast, or simple lunch only <input type="checkbox"/> 3 Simple microwave or crockpot meal <input type="checkbox"/> 4 Regular meals	Total _____
<b>Housekeeping</b>	<input type="checkbox"/> 1 Unable <input type="checkbox"/> 2 Light dusting, straighten up <input type="checkbox"/> 3 Regular housekeeping in small steps or with help <input type="checkbox"/> 4 Fully capable	Total _____
<b>Grocery Shopping</b>	<input type="checkbox"/> 1 Unable <input type="checkbox"/> 2 Occasional (once or twice per month) <input type="checkbox"/> 3 Frequent, but with assistance <input type="checkbox"/> 4 No problem	Total _____
<b>Social Activities</b> Church, temple, family and friends	<input type="checkbox"/> 1 Unable <input type="checkbox"/> 2 Infrequently <input type="checkbox"/> 3 Occasionally (once or twice per month) <input type="checkbox"/> 4 Frequently (weekly or more often)	Total _____
<b>Driving</b>	<input type="checkbox"/> 1 Unable <input type="checkbox"/> 2 Very limited <input type="checkbox"/> 3 Cautious, local trips <input type="checkbox"/> 4 Distant trips or traffic	Total _____
<b>Errands or Light Chores</b> Post office, drop off a child	<input type="checkbox"/> 1 None <input type="checkbox"/> 2 0-1 per day <input type="checkbox"/> 3 2-3 per day <input type="checkbox"/> 4 No or few restrictions	Total _____
		<b>Grand Total</b> _____