RADIANTLY HEALTHY

New Female Patient Packet

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PLEASE COMPLETE THE FOLLOWING FORM.

SAVE THIS FORM TO YOUR COMPUTER OR DEVICE AND EMAIL TO NEWPATIENT@RH-MD.COM.
YOU MAY ALSO PRINT THE FORM, FILL IT OUT AND BRING IT INTO OUR OFFICE.

GENERAL INFORMATION

Name: _____
First *Middle* *Last*

Date of Birth: _____ **Gender:** ☐ **Male** ☐ **Female**

Genetic Background: ☐ **African** ☐ **European** ☐ **Native American** ☐ **Mediterranean**
☐ **Asian** ☐ **Ashkenazi** ☐ **Middle Eastern** ☐ _____

Highest Education Level: ☐ **High School** ☐ **Under-Graduate** ☐ **Post-Graduate**

Employer: _____

Job Title: _____

Primary Address: _____
House Number and Street *Apt. No.*

_____
City *State* *Zip*

Alternate Address: _____
House Number and Street *Apt. No.*

Preferred Contact Method ☐

Home Phone: _____ ☐ **Work Phone:** _____ ☐

Cell Phone: _____ ☐ **Fax Number:** _____ ☐

Email: _____ ☐

OK to Receive Text Messages About Appts etc? ☐

Emergency Contact: **Name:** _____ **Phone Number:** _____

Address: _____

_____

Primary Care Physician Name: _____

Phone Number: _____ **Fax:**_____

Referred by: ☐ **Website** ☐ **Magazine Article** ☐ **Friend/Family** _____
☐ **Natural Awakenings** ☐ **Space Coast Living** ☐ **Other Doctor** _____

Health Goals

What would be your top 3 things you want to achieve with our partnership in your health and wellness journey?

1. _____

2. _____

3. _____

When was the last time you felt well? _____

_____

_____

Did Something trigger your change in health? _____

_____

_____

What makes you feel better? _____

_____

_____

What makes you feel worse? _____

_____

_____

How does your condition affect you? _____

_____

_____

What do you think is happening and why? _____

_____

_____

What do you feel needs to happen for you to get better? _____

_____

_____

MSQ - Medical Symptom/Toxicity Questionnaire

NAME: _____ **DATE:** _____

The Toxicity and Symptom Screening Questionnaire identifies symptoms that help to identify the underlying causes of illness and helps you track your progress over time. Rate each of the following symptoms based upon your health profile for the past 30 days. If related to previous questionnaire, please record your symptoms for past 48 hours.

POINT SCALE

0 = Never of 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

DIGESTIVE TRACT

___ Nausea or vomiting
___ Diarrhea
___ Constipation
___ Bloated feeling
___ Belching or passing gas
___ Heartburn
___ Intestinal/stomach pain
TOTAL _____

EARS

___ Itchy ears
___ Earaches, ear infections
___ Drainage from ear
___ Ringing in ears, hearing loss
TOTAL _____

EMOTIONS

___ Mood Swings
___ Anxiety, irritability, aggressiveness
___ Depression
TOTAL _____

ENERGY/ACTIVITY

___ Fatigue, sluggishness
___ Apathy, lethargy
___ Hyperactivity
___ Restlessness
TOTAL _____

EYES

___ Watery or itchy eyes
___ Swollen, reddened, sticky eyelids
___ Bags or dark circles under eyes
___ Blurred or tunnel visions (does not include near or far-sightedness)
TOTAL _____

HEAD

___ Headaches
___ Faintness
___ Dizziness
___ Insomnia
TOTAL _____

HEART

___ Irregular or skipped heartbeat
___ Rapid or pounding heartbeat
___ Chest pain
TOTAL _____

JOINT/MUSCLES

___ Pain or aches in joints
___ Arthritis
___ Stiffness, limitation of movement
___ Pain or aches in muscles
___ Feeling of weakness or tiredness
TOTAL _____

LUNGS

___ Chest congestion
___ Asthma, bronchitis
___ Shortness of breath
___ Difficulty breathing
TOTAL _____

MIND

___ Poor memory
___ Confusion, poor comprehension
___ Poor concentration
___ Poor physical coordination
___ Difficulty in making decisions
___ Stuttering or stammering
___ Slurred speech
___ Learning disabilities
TOTAL _____

MOUTH/THROAT

___ Chronic coughing
___ Gagging: frequent need to clear throat
___ Sore throat; hoarseness; loss of voice
___ Swollen/discolored tongue, gum, lips
TOTAL _____

NOSE

___ Stuffy nose
___ Sinus problems
___ Hay fever
___ Sneezing attacks
___ Excessive mucus formation
TOTAL _____

SKIN

___ Acne
___ Hives, rashes or dry skin
___ Hair loss
___Flushing or hot flashes
___ Excessive sweating
TOTAL _____

WEIGHT

___ Binge eating/drinking
___ Craving certain foods
___ Excessive weight
___ Compulsive eating
___ Water retention
___ Underweight
TOTAL _____

OTHER

___ Frequent illness
___ Frequent or urgent urination
___ Genital itch or discharge
TOTAL _____

GRAND TOTAL _____ **Add individual scores and total each group. Add each group scores and give a grand total.**

KEY - Optimal is less than 10 Mild Toxicity: 10-50 Moderate Toxicity: 50-100 Severe Toxicity: 100+

Allergies

Name of Medication/Supplement/Food	Reaction
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Lifestyle Review

SLEEP

How many hours of sleep do you get each night on average? _____

Do you have problems falling asleep? ☐ Yes ☐ No Staying asleep? ☐ Yes ☐ No

Do you have problems with insomnia? ☐ Yes ☐ No Do you snore? ☐ Yes ☐ No

Do you feel rested upon awakening? ☐ Yes ☐ No

Do you use sleeping aids? ☐ Yes ☐ No

If yes, explain: _____

EXERCISE

Current Exercise Program:

ACTIVITY	TYPE	# OF TIMES PER WEEK	TIME/DURATION (MINUTES)
Cardio/Aerobic			
Strength/Resistance			
Flexibility/Stretching			
Balance			
Sports/Leisure (e.g. golf)			
Other:			

Do you feel motivated to exercise? ☐ Yes ☐ A little ☐ No

Are there any problems that limit exercise? ☐ Yes ☐ No

Do you feel unusually fatigued or sore after exercise? ☐ Yes ☐ No

If yes, explain: _____

NUTRITION

Do you currently follow any of the following special diets or nutritional programs? *(Check all that apply)*

☐ Vegetarian ☐ Vegan ☐ Allergy ☐ Elimination ☐ Low Fat ☐ Low Carb
☐ High Protein ☐ Blood Type ☐ Low Sodium ☐ No Dairy ☐ No Wheat ☐ Gluten Free

Other: _____

Do you have sensitivities to certain foods? ☐ Yes ☐ No

If yes, list food and symptoms: _____

Do you have an aversion to certain foods? ☐ Yes ☐ No

If yes, list food and symptoms: _____

Do you adversely react to: *(Check all that apply)*

☐ Monosodium glutamate (MSG) ☐ Artificial sweeteners ☐ Garlic/onion ☐ Cheese ☐ Citrus foods
☐ Chocolate ☐ Alcohol ☐ Red wine ☐ Sulfite-containing foods (wine, dried fruit, salad bars)
☐ Preservatives ☐ Food colorings ☐ Other food substances: _____

Are there any foods that you crave or binge on? ☐ Yes ☐ No

If yes, what foods: _____

Do you eat 3 meals a day? ☐ Yes ☐ No **If no, how many** _____

Does skipping a meal greatly affect you? ☐ Yes ☐ No
How many meals you eat out per week? ☐ 0-1 ☐ 1-3 ☐ 3-5 ☐ >5 meals per week

Check the factors that apply to your current lifestyle and eating habits:

☐ Fat eater
☐ Eat too much
☐ Late-night eating
☐ Dislike healthy foods
☐ Time constraints
☐ Travel frequently
☐ Eat more than 50% of meals away from home
☐ Healthy foods not readily available
☐ Poor snack choices
☐ Significant other or family members don't like health foods
☐ Significant other or family members have special dietary needs
☐ Love to eat
☐ Eat because I have to
☐ Have negative relationship with food
☐ Struggle with eating issues
☐ Emotional eater (eat when sad, lonely, bored, etc)
☐ Eat too much under stress
☐ Eat too little under stress
☐ Don't care to cook
☐ Confused about nutrition advice

SMOKING

Do you smoke currently? ☐ Yes ☐ No Packs per day: _____ Number of years: _____

What type? ☐ Cigarettes ☐ Smokeless ☐ Pipe ☐ Cigar ☐ E-Cig

Have you attempted to quite? ☐ Yes ☐ No

If yes, using what methods? _____

If you smoked previously: Packs per day: _____ Number of years: _____

Are you regularly exposed to second-hand smoke? ☐ Yes ☐ No

ALCOHOL

How many alcoholic beverages do you drink in a week? *(1 drink = 5 ounces wine, 12 ounces beer, 1.5 ounces spirits)*

☐ 1-3 ☐ 4-6 ☐ 7-10 ☐ >10 ☐ None

Previous alcohol intake? ☐ Yes (☐ Mild ☐ Moderate ☐ High) ☐ None

Have you ever had a problem with alcohol? ☐ Yes ☐ No

If yes, when? _____

Explain the problem: _____

Have you ever thought about getting help to control or stop your drinking? ☐ Yes ☐ No

OTHER SUBSTANCES

Are you currently using any recreational drugs? ☐ Yes ☐ No

If yes, type: _____

Have you ever used IV or inhaled recreational drugs? ☐ Yes ☐ No

STRESS

Do you feel you have an excessive amount of stress in your life? ☐ Yes ☐ No

Do you feel you can easily handle stress in your life? ☐ Yes ☐ No

How much stress do each of the following cause on a daily basis *(Rate on scale of 1-10, 10 being highest)*

☐ Work ☐ Family ☐ Social ☐ Finances ☐ Health ☐ Other

Do you use relaxation techniques? ☐ Yes ☐ No

If yes, how often? _____

Which techniques do you use? *(Check all that apply)*

☐ Mediation ☐ Breathing ☐ Tai Chi ☐ Yoga ☐ Prayer ☐ Other

Have you sought counseling? ☐ Yes ☐ No

Are you currently in therapy? ☐ Yes ☐ No

If yes, describe: _____

Have you ever been abused, a victim of crime, or experiences a significant trauma? ☐ Yes ☐ No

What are your hobbies or leisure activities? _____

RELATIONSHIPS

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Gay/Lesbian ☐ Long-Term Partner ☐ Widow/er

With whom do you live? (Include children, parents, relatives, friends, pets) _____

_____

Current occupation: _____

Previous occupation: _____

Do you have resources for emotional support? ☐ Yes ☐ No *(Check all that apply)*

☐ Spouse/Partner ☐ Family ☐ Friends ☐ Religious/Spiritual ☐ Pets ☐ Other: _____

Do you have a religious or spiritual practice? ☐ Yes ☐ No

If yes, what kind? _____

How well have things been going for you? *(Mark on a scale of 1-10, or N/A if not applicable)*

	N/A	POORLY									VERY WELL
Overall	☐	1	2	3	4	5	6	7	8	9	10
At School	☐	1	2	3	4	5	6	7	8	9	10
In your job	☐	1	2	3	4	5	6	7	8	9	10
In your social life	☐	1	2	3	4	5	6	7	8	9	10
With close friends	☐	1	2	3	4	5	6	7	8	9	10
With sex	☐	1	2	3	4	5	6	7	8	9	10
With your attitude	☐	1	2	3	4	5	6	7	8	9	10
With your boyfriend/girlfriend	☐	1	2	3	4	5	6	7	8	9	10
With your children	☐	1	2	3	4	5	6	7	8	9	10
With your parents	☐	1	2	3	4	5	6	7	8	9	10
With your spouse	☐	1	2	3	4	5	6	7	8	9	10

HISTORY

PATIENTS BIRTH/CHILDHOOD HISTORY:

You were born: ☐ Term ☐ Premature ☐ Don't know

Were there any pregnancy or birth complications? ☐ Yes ☐ No

If yes, explain: _____

You were: ☐ Breast-fed/How long? _____ ☐ Bottle fed/Type of formula: _____ ☐ Don't know

Age of introduction of: Solid food: _____ Wheat: _____ Dairy: _____

As a child, were there any foods that were avoided because they gave you symptoms? ☐ Yes ☐ No

If yes, what foods and what symptoms? (Example: milk - gas and diarrhea)

_____

Did you eat a lot of sugar or candy as a child? ☐ Yes ☐ No

DENTAL HISTORY: ***Check if you have any of the following, and provide number if applicable:***

☐ Silver Mercury Filings_____ ☐ Gold Fillings _____ ☐ Root Canals _____ ☐ Implants _____

☐ Caps/Crowns _____ ☐Tooth Pain_____ ☐ Bleeding gums _____ ☐Gingivitis _____

☐ Problems with chewing _____ ☐ Other dental concerns (explain): _____

Have you had any mercury fillings removed? ☐ Yes ☐ No If yes, when?: _____

How many fillings did you have as a kid? _____

Do you brush regularly? ☐ Yes ☐ No Do you floss regularly? ☐ Yes ☐ No

ENVIRONMENTAL/DETOXIFICATION HISTORY

Do any of these significantly affect you?

☐ Cigarette smoke ☐ Perfume/colognes ☐ Auto exhaust fumes ☐ Other: _____

If you work or home environment are you regularly exposed to: *(Check all that apply)*

☐ Mold Water leaks ☐ Renovations ☐ Chemicals ☐ Electromagnetic radiation

☐ Damp environments ☐ Carpets or rugs ☐ Old paint ☐ Stagnant or stuffy air ☐ Smokers

☐ Pesticides ☐ Herbicides ☐ Harsh chemicals (solvents, glues, gas, acids, etc) ☐ Cleaning chemicals

☐ Heavy metals (lead, mercury, etc.) ☐ Paints ☐ Airplane travel ☐ Other: _____

If yes: Chemical name, length of exposure, date: _____

Do you have any pets or farm animals? ☐ Yes ☐ No

If yes, do they live: ☐ Inside ☐ Outside ☐ Both inside and outside

WOMEN'S HISTORY

Obstetric History *(Check box if applicable)*

☐ Pregnancies _____ ☐ Miscarriages _____ ☐ Abortions _____ ☐ Living children _____

☐ Vaginal deliveries _____ ☐ Cesarean _____ ☐ Term births _____ ☐ Premature birth _____

Birth weight of largest baby _____ Birth weight of smallest baby _____

Did you develop any problems in or after pregnancy, for example, toxemia (high blood pressure), diabetes, postpartum depression, issues with breast feeding, etc.? ☐ Yes ☐ No

If yes, please explain _____

Menstrual History

Age of first period _____ **Date of last menstrual period** _____

Length of cycle _____ **Time between cycles** _____

Cramping? ☐ **Yes** ☐ **No** **Pain?** ☐ **Yes** ☐ **No**

Have you ever had premenstrual problems? (bloating, breast tenderness, irritability, etc.?) ☐ **Yes** ☐ **No**

If yes, please describe: _____

Do you have other problems with your periods (heavy, irregular, spotting, skipping, etc.?) ☐ **Yes** ☐ **No**

If yes, please describe: _____

Use of hormonal birth control: ☐ **Birth control pills** ☐ **Patch** ☐ **Nuva ring**

☐ **Other** _____ **How long** _____

Any problems with hormonal birth control? ☐ **Yes** ☐ **No**

If yes, please describe: _____

Use of other contraception? ☐ **Yes** ☐ **No** ☐ **Condoms** ☐ **Diaphragm** ☐ **IUD** ☐ **Partner vasectomy**

Are you in menopause? ☐ **Yes** ☐ **No** **If yes, age at last period:** _____

Was it surgical menopause? ☐ **Yes** ☐ **No**

If yes, explain surgery: _____

Do you currently have symptomatic problems with menopause? (*Check all that apply)*

☐ **Hot flashes** ☐ **Mood swings** ☐**Concentration/memory problems** ☐ **Headaches** ☐ **Joint pain**

☐ **Vaginal dryness** ☐ **Weight gain** ☐ **Decreased libido** ☐ **Loss of control of urine** ☐ **Palpitations**

Are you on hormone replacement therapy? ☐ **Yes** ☐ **No**

If yes, for how long and for what reason (hot flashes, osteoporosis prevention, etc.)? _____

_____

Other Gynecological Symptoms: (*Check if applicable)*

☐ **Endometriosis** ☐ **Infertility** ☐ **Fibrocystic breasts** ☐ **Vaginal infection** ☐ **Fibroids**

☐ **Ovarian cysts** ☐ **Pelvic inflammatory disease** ☐ **Reproductive cancer**

☐ **Sexually transmitted disease (describe)** _____

_____

Gynecological Screening/Procedures *(If applicable, provide date)*

Last Pap test: _____ ☐ **Normal** ☐ **Abnormal**

Last mammogram: _____ ☐ **Normal** ☐ **Abnormal**

Last bone density: _____ **Results:** ☐ **High** ☐ **Low** ☐ **Within Normal Range**

Other tests/procedures (list type and dates) _____

_____

FAMILY HISTORY

Check family members that apply	Mother	Father	Brother(s)	Sisters(s)	Child	Child	Child	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Other
Age (if still alive)												
Age at death (if deceased)												
Cancers	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Obesity	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Auto Immune Diseases (such as lupus)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Thyroid problems	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Seizures/epilepsy	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Psychiatric Disorders	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Anxiety	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Eczema/Psoriasis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Allergies	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Eczema	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
ADHD	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Autism	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Irritable Bowel Syndrome	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Dementia	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Substance abuse	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Genetic disorders	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other: _____	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

MEDICAL HISTORY: ILLNESSES/CONDITIONS

Check YES = a condition you currently have, CHECK PAST = a condition you've had in the past

Gastrointestinal	Yes	Past
Irritable bowel syndrome		
GERD (reflux)		
Crohn's disease/ulcerative colitis		
Peptic ulcer disease		
Celiac disease		
Gallstones		
Other:		
Respiratory		
Bronchitis		
Asthma		
Emphysema		
Pneumonia		
Sinusitis		
Sleep apnea		
Other:		
Urinary/Genital		
Kidney stones		
Gout		
Interstitial cystitis		
Frequent yeast infections		
Frequent urinary tract infections		
Sexual dysfunction		
Sexually transmitted diseases		
Other:		
Endocrine/Metabolic		
Diabetes		
Hypothyroidism (low thyroid)		
Hyperthyroidism (overactive thyroid)		
Infertility		
Metabolic syndrome/Insulin resistance		
Eating disorder		
Hypoglycemia		
Other:		
Inflammatory/Immune		
Rheumatoid arthritis		
Chronic fatigue syndrome		
Food allergies		
Environmental allergies		
Multiple chemical sensitivities		
Autoimmune disease		
Immune deficiency		
Mononucleosis		
Hepatitis		

Other:		
Musculoskeletal	**Yes**	**Past**
Fibromyalgia		
Osteoarthritis		
Chronic pain		
Other:		
Skin		
Eczema		
Psoriasis		
Acne		
Skin cancer		
Other:		
Cardiovascular		
Angina		
Heart attack		
Heart failure		
Hypertension (high blood pressure)		
Stroke		
High blood fats (cholesterol, triglycerides)		
Rheumatic fever		
Arythmia (irregular heart rate)		
Murmur		
Mitral valve prolapse		
Other:		
Neurologic/Emotional		
Epilepsy/Seizures		
ADD/ADHD		
Heartaches		
Migraines		
Depression		
Anxiety		
Autism		
Multiple sclerosis		
Parkinson's disease		
Dementia		
Other:		
Cancer		
Lung		
Breast		
Colon		
Prostate		
Skin		
Other:		

MEDICAL HISTORY (cont.)

Diagnostic Studies	Date	Comments
Bone density		
CT Scan		
Colonoscopy		
Cardiac stress test		
EKG		
MRI		
Upper endoscopy		
Upper GI series		
Chest X-ray		
Barium enema		
Other:		
Injuries		
Broken bone(s)		
Back injury		
Neck injury		
Head injury		
Other:		
Surgeries		
Appendectomy		
Dental		
Gallbladder		
Hernia		
Hysterectomy		
Tonsillectomy		
Joint replacement		
Heart surgery		
Other:		
Hospitalization	**Date**	**Reason**

MEDICATION

CURRENT MEDICATIONS (include prescription and over-the-counter)

Medication	Dosage	Start Date (mo/yr)	Reason For Use

Nutrional supplements (vitamins/minerals/herbs etc.)

Name and Brand	Dosage	Start Date (mo/yr)	Reason For Use

Have medications or supplements ever caused unusual side effects or problems? ☐ Yes ☐ No

If yes, describe: _____

Have you used any of these regularly or for a long time:

NSAIDS (Advil, Aleve, etc.), Motrin, or Aspirin? ☐ Yes ☐ No Tylenol (acetaminophen)? ☐ Yes ☐ No

Acid Blocking Drugs? (Tagamet, Zantac, Prilosec, etc.) ☐ Yes ☐ No

READINESS ASSESSMENT

Rate on a scale of: 5 (very willing) to 1 (not willing).

In order to improve your health, how willing are you to:

Significantly modify diet: ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

Take several nutritional supplements each day: ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

Keep a record of everything you eat each day: ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

Modify lifestyle [‘e.g., work, demands, sleep habits): ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

Practice a relaxation technique: ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

Engage in regular exercise: ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

Rate on a scale of: 5 (very confident) to 1 (not confident at all)

How confident are you of your ability to organize and follow through on the above health related activities?

☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

If you are not confident of your ability, what aspects of yourself or life lead you to question your capacity to follow through?

_____

_____

_____

Rate on a scale of: 5 (very supportive) to 1 (very unsupportive)

At the present time, how supportive do you think the people in your household will be to your implementing the above changes?

☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

Rate on a scale of: 5 (very frequent contact) to 1 (very infrequent contact)

How much on-going support (e.g. telephone consults, email correspondence) from our professional staff would be helpful to you as you implement a personal health program? ☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

Comments: _____

_____

Diet, Nutrition, and Lifestyle Journal - 3 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

RADIANTLY HEALTHY

Diet, Nutrition, and Lifestyle Journal - 3 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

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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
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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

RADIANTLY
HEALTHY

THANK YOU FOR COMPLETING THIS FORM.

PLEASE SAVE THIS FORM TO YOUR COMPUTER OR DEVICE AND EMAIL TO NEWPATIENT@RH-MD.COM.

YOU MAY ALSO PRINT THE FORM, FILL IT OUT AND BRING IT INTO OUR OFFICE.