

FirstLineTherapy[®]

Establishing Your Health Goals

Date: _____
 Name: _____
 Age: _____
 Referred by: _____

Fill in your current Health Goals.	Office Use		
Health Goals	Change +/-	Stage of Change	Technique/Plan
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Diet Diary / Exercise Log

Name: _____

Please complete your "Diet Diary / Exercise Log" every day.

- 1.) Make note of the time you wake up.
- 2.) List and describe in detail all foods and drinks including the amount of each. Make note as to whether the food was fresh, frozen, canned, raw, cooked, baked, fried, etc. Note the time of each meal or snack. Be sure to list everything you eat or drink, including any condiments used (i.e. mayonaise, mustard, relish, etc.).
- 3.) Keep track of how much water you drink and list the amount in ounces in the section provided. Also note the type and amount of any other drinks you consume.
- 4.) Write down any activity or exercise you do in the section at the bottom, listing the kind of exercise you did and for how long you did it.
- 5.) Note any periods of relaxation and what kind of relaxation it was.
- 6.) Note the time you go to sleep.

Day 1	Date:
Wake up:	
Morning Meal	
Time:	
Snack	
Time:	
Mid-Day Meal	
Time:	
Snack	
Time:	
Evening Meal	
Time:	
Snack	
Time:	
Water (ounces)	
Other Drinks <small>(that are not listed with meals or snacks above)</small>	
Activity/Exercise What kind: How long:	
Relaxation type: How long:	
sleep time:	

Diet Diary / Exercise Log

	Day 2 - Date:	Day 3 - Date:
Wake up:		
Morning Meal		
Time:		
Snack		
Time:		
Mid-Day Meal		
Time:		
Snack		
Time:		
Evening Meal		
Time:		
Snack		
Time:		
Water (ounces)		
Other Drinks <small>(that are not listed with meals or snacks above)</small>		
Activity/Exercise What kind: How long:		
Relaxation type: How long:		
sleep time:		

FirstLineTherapy® Health Profile

NAME _____

DATE _____

WEEK _____

Rate each of the following symptoms based upon your typical health profile for: Past 30 days Past 48 hours

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

DIGESTIVE TRACT _____ Nausea, vomiting
 _____ Diarrhea
 _____ Constipation
 _____ Bloating feeling
 _____ Belching, passing gas
 _____ Heartburn
 _____ Intestinal/stomach pain
 _____ 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

JOINTS/ MUSCLE _____ Pain or aches in joints
 _____ Arthritis
 _____ Stiffness or limitation of movement
 _____ Pain or aches in muscles
 _____ Feeling of weakness or tiredness
 _____ TOTAL

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

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

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

ENERGY/ ACTIVITY _____ Fatigue, sluggishness
 _____ Apathy, lethargy
 _____ Hyperactivity
 _____ Restlessness
 _____ TOTAL

MOUTH/ THROAT _____ Chronic coughing
 _____ Gagging, frequent need to clear throat
 _____ Sore throat, hoarseness, loss of voice
 _____ Swollen or discolored tongue, gums or lips
 _____ Canker sores
 _____ TOTAL

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

SKIN _____ Acne
 _____ Hives, rashes, dry skin
 _____ Hair loss
 _____ Flushing, hot flashes
 _____ Excessive sweating
 _____ TOTAL

EMOTIONS _____ Mood swings
 _____ Anxiety, fear, nervousness
 _____ Anger, irritability, aggressiveness
 _____ Depression
 _____ TOTAL

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

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

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

GRAND TOTAL _____