New Patient Packet

150 5th Ave, Suite C
Indialantic, FL 32903

(321)254.6803
Fax (321)254.6819

www.drhunton.com
admin@rh-md.com

General Information

Name: ____
First *Middle* *Last*

Date of Birth: ______________________________________ Age: ______________________

Gender: ❑ Male ❑ Female Social Security Number: ______________________

Genetic Background: ❑ African ❑ European ❑ Native American ❑ Mediterranean
❑ Asian ❑ Ashkenazi ❑ Middle Eastern ❑ ___________

Highest Education Level: ❑ High School ❑Under-Graduate ❑ Post-Graduate

Job Title: ____

Nature of Business:____

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

____
City *State* *Zip*

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

____
City *State* *Zip*

Home Phone: ____________________________ Work Phone: ____________________________

Cell Phone: ____________________________ Fax Number: ____________________________

Email: ____

Emergency Contact: Name:____________________________ Phone Number:__________________

Address:____

____

Physician: Name:____

Phone Number:______________________ Fax: _________________________

Referred by: ❑Website ❑Magazine Article ❑Friend/Family____________________
❑Natural Awakenings ❑Space Coast Living ❑Other Doctor_____________________

Pharmacy Information

Primary Pharmacy: Name:________________________________ Phone Number:______________________

Address:______________________________ City:_______________________________

State:________________________________ Zip:_______________________________

Email:________________________________ Fax:*_____________________________

It is extremely important that you list the pharmacy's fax number.

Compounding Pharmacy: Name:________________________________ Phone Number:______________________

Address:______________________________ City:_______________________________

State:________________________________ Zip:_______________________________

Email:________________________________ Fax:*_____________________________

It is extremely important that you list the pharmacy's fax number.

Lab Information

Primary Lab: Name:________________________________ Phone Number:______________________

Address:______________________________ City:_______________________________

State:________________________________ Zip:_______________________________

Email:________________________________ Fax:*_____________________________

It is extremely important that you list the lab's fax number.

Health Insurance Information

Insurance information is for the purpose of prescriptions, lab orders and referrals

Health Insurance Plan:____________________________ Policy Holder Name:_______________________

Policy Holder D.O.B.:________________________________ Relationship to Patient ❑Self ❑Spouse ❑Other

Type: ❑Insurance ❑Medicare ❑Medicare Advantage ❑Medicaid ❑Tri-Care

Policy Number:______________________________ Group Number:_____________________________

Mailing Address:____

____

Phone Number:____

Credit Card Information

Date: ____________________________

Patient:____ DOB:_____________________________

Preferred Method of Payment (please check **one**): ❑Cash ❑Check ❑Credit Card

If paying by credit card, we accept VISA, MasterCard, and Discover*

***Note: If Discover is your primary card, please provide another card (i.e., MasterCard or Visa) for transactions (i.e., supplement orders, etc.) that we may need to process. Some pharmacies do not accept Discover.**

PRIMARY CARD

Name on Card: ____________________________

Card Type: ❑Visa ❑MasterCard ❑Discover

Account Number:___________________________

Expiration Date (mm/yy): ___________

CVV#:_______

SECONDARY CARD

Name on Card: ____________________________

Card Type: ❑Visa ❑MasterCard ❑Discover

Account Number: __________________________

Expiration Date (mm/yy): ___________

CVV#: _______

Medical Questionnaire

Allergies

Medication/Supplement/Food:	Reaction:
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

Complaints/Concerns

What do you hope to achieve in your visit with us?____

____

If you had a magic wand and could erase three problems, what would they be?

1.____

2.____

3.____

When was the last time you felt well? ____

____

Did something trigger your change in health?____

____

What makes you feel worse?____

____

What makes you feel better?____

____

Please list current and ongoing problems in order of priority:

Describe Problem	Mild	Moderate	Severe	Prior Treatment/Approach	Excellent	Good	Fair
example: post nasal drip		*x*		*elimination diet*	*x*		

RH MD
RADIANTLY HEALTHY

Medical History

☑ = Past Condition ☑=Ongoing Condition

DISEASES/DIAGNOSIS/CONDITIONS *Check appropriate box and provide date of onset*

GASTROINTESTINAL
❑ ❑ Irritable Bowel Syndrome
❑ ❑ Inflammatory Bowel Disease
❑ ❑ Crohn's
❑ ❑ Ulcerative Colitis
❑ ❑ Gastritis o❑r Peptic Ulcer Disease
❑ ❑ GERD (reflux)
❑ ❑ Celiac Disease
❑ ❑ Other

CARDIOVASCULAR
❑ ❑ Heart Attack
❑ ❑ Other Heart Disease
❑ ❑ Stroke
❑ ❑ Elevated Cholesterol
❑ ❑ Arrythmia (irregular heart rate)
❑ ❑ Hypertension (high blood pressure)
❑ ❑ Rheumatic Fever
❑ ❑ Mitral Valve Prolapse
❑ ❑ Other

METABOLIC/ENDOCRINE
❑ ❑ Type 1 Diabetes
❑ ❑ Type 2 Diabetes
❑ ❑ Hypoglycemia
❑ ❑ Metabolic Syndrome
(Insulin Resistance or Pre-Diabetes)
❑ ❑ Hypothyroidism (low thyroid)
❑ ❑ Hyperthyroidism (overactive thyroid)
❑ ❑ Endocrine Problems
❑ ❑ Polycystic Ovarian Syndrome (PCOS)
❑ ❑ Infertility
❑ ❑ Weight Gain
❑ ❑ Weight Loss
❑ ❑ Frequent Weight Fluctuations
❑ ❑ Bulimia
❑ ❑ Anorexia
❑ ❑ Binge Eating Disorder
❑ ❑ Night Eating Syndrome
❑ ❑ Eating Disorder (non-specific)
❑ ❑ Other

GENITAL AND URINARY SYSTEMS
❑ ❑ Kidney Stones
❑ ❑ Gout
❑ ❑ Interstitial Cystitis
❑ ❑ Frequent Urinary Tract Infections
❑ ❑ Frequent Yeast Infections
❑ ❑ Erectile Dysfunction
❑ ❑ Sexual Dysfunction
❑ ❑ Other

MUSCULOSKELETAL/PAIN
❑ ❑ Osteoarthritis
❑ ❑ Fibromyalgia
❑ ❑ Chronic Pain
❑ ❑ Other

INFLAMMATORY/AUTOIMMUNE
❑ ❑ Chronic Fatigue Syndrome
❑ ❑ Autoimmune Disease
❑ ❑ Rheumatoid Arthritis
❑ ❑ Lupus SLE
❑ ❑ Immune Deficiency Disease
❑ ❑ Herpes-Genital
❑ ❑ Severe Infectious Disease
❑ ❑ Poor Immune Function
(frequent infections)
❑ ❑ Food Allergies
❑ ❑ Environmental Allergies
❑ ❑ Multiple Chemical Sensitivities
❑ ❑ Latex Allergy
❑ ❑ Other

RESPIRATORY DISEASES
❑ ❑ Asthma
❑ ❑ Chronic Sinusitis
❑ ❑ Bronchitis
❑ ❑ Emphysema
❑ ❑ Pneumonia
❑ ❑ Tuberculosis
❑ ❑ Sleep Apnea
❑ ❑ Other

CANCER

- ❑ ❑Lung Cancer
- ❑ ❑Breast Cancer
- ❑ ❑Colon Cancer
- ❑ ❑Ovarian Cancer
- ❑ ❑Prostate Cancer
- ❑ ❑Skin Cancer

NEUROLOGIC/MOOD

- ❑ ❑Depression
- ❑ ❑Anxiety
- ❑ ❑Bipolar Disorder
- ❑ ❑Schizophrenia
- ❑ ❑Headaches
- ❑ ❑Migraines
- ❑ ❑ADD/ADHD

SKIN DISEASES

- ❑ ❑Eczema
- ❑ ❑Psoriasis
- ❑ ❑ Acne
- ❑ ❑ Melanoma
- ❑ ❑Skin Cancer
- ❑ ❑Other
- ❑ ❑ Autism
- ❑ ❑ Mild Cognitive Impairment
- ❑ ❑Memory Problems
- ❑ ❑ Parkinson's Disease
- ❑ ❑ Multiple Sclerosis
- ❑ ❑ ALS
- ❑ ❑ Seizures
- ❑ ❑Other Neurological Problems

PREVENTIVE TESTS AND DATE OF LAST TEST

Check box if yes and provide date

- ❑Full Physical Exam
- ❑Bone Density
- ❑Colonoscopy
- ❑Cardiac Stress Test
- ❑EBT Heart Scan
- ❑EKG
- ❑Hemoccult Test-stool test for blood
- ❑MRI
- ❑CT Scan
- ❑Upper Endoscopy
- ❑Upper GI Series
- ❑Ultrasound

SURGERIES

Check box if yes and provide date of surgery

- ❑ Appendectomy
- ❑ Hysterectomy +/- Ovaries
- ❑Gall Bladder
- ❑Hernia
- ❑Tonsillectomy
- ❑ Dental Surgery
- ❑ Joint-Replacement-Knee/Hip
- ❑ Heart Surgery-Bypass Valve
- ❑ Angioplasty or Stent
- ❑Pacemaker
- ❑Other____
- ❑None

INJURIES

Check box if yes

❑Back Injury ❑Head Injury
❑Neck Injury ❑Broken Bones
❑Other

BLOOD TYPE

❑A ❑B ❑AB ❑O
❑Rh+ ❑unknown

HOSPITALIZATIONS

❑None

Date	Reason

GYNECOLOGIC HISTORY *(for women only)*

OBSTETRIC HISTORY *Check box if yes and provide number of*

❑Pregnancies________ ❑Caesarean________ ❑ Vaginal Deliveries________
❑Miscarriage________ ❑Abortion_________ ❑ Living Children__________
❑Post Partum Depression ❑Toxemia ❑Gestational Diabetes ❑Baby Over 8 Pounds
❑Breast Feeding, For how long?_______________ ❑Date of last Mammogram?_____________________

MENSTRUAL HISTORY

Age at First Period:________ Menses Frequency:________ Length:________ Pain: ❑Yes ❑No Clotting: ❑Yes ❑ No
Has your period ever skipped?__________ For how long?__________
Last Menstrual Period:________
Use of hormonal contraception such as: ❑ Birth Control Pills ❑ Patch ❑Nuva Ring,How long?__________
Do you use contraception? ❑Yes ❑ No ❑Condom ❑Diaphragm ❑ IUD ❑Partner Vasectomy

WOMEN'S DISORDERS/HORMONAL IMBALANCES

❑Fibrocystic Breasts ❑Endometriosis ❑Fibroids ❑Infertility
❑Painful Periods ❑Heavy Periods ❑Pms
Last Mammogram:____________________ Breast Biopsy/Date:___________________
Last PAP Test:___________________ ❑Normal ❑Abnormal
Last Bone Density:_______________ Results: ❑High ❑Low ❑Within Normal Range
Are you in menopause? ❑No ❑ Yes, Age at Menopause: _____________________________________
❑Hot Flashes ❑Mood Swings ❑Concentration/Memory Problems ❑Vaginal Dryness ❑Decreased Libido
❑Heavy Bleeding ❑Joint Pains ❑Headaches ❑Weight Gain ❑Loss of Control of Urine ❑Palpitations
Use of hormone replacement therapy? ❑No ❑ Yes, For how long: _____________________________________

MEN'S HISTORY *(for men only)*

Have you had a PSA done? ❑Yes ❑No
PSA Level: ❑0-2 ❑2-4 ❑4-10 ❑>10
❑Prostate Enlargement ❑Prostate Infection ❑Change in Libido ❑Impotence
❑Difficulty Obtaining an Erection ❑Difficulty Maintaining an Erection
❑Nocturia (urination at night). How many times at night?________________________
❑Urgency/Hesitancy/Change in Urinary Stream ❑Loss of Control of Urine

DENTAL HISTORY

DENTAL SURGERY

Silver Mercury Fillings ❑No ❑Yes, How many?___________________
❑Gold Fillings ❑Root Canals ❑Implants ❑Tooth Pain ❑Bleeding Gums
❑Gingivitis ❑Problems with Chewing Do you floss regularly? ❑Yes ❑No

GI HISTORY

Foreign Travel? ❑No ❑Yes, Where?____
Wilderness Camping? ❑No ❑Yes, Where?____
Have you ever had severe: ❑Gastroenteritis ❑Diarrhea
Do you feel like you digest your food well? ❑Yes ❑No
Do you feel bloated after meals? ❑Yes ❑No

PATIENT BIRTH HISTORY (these questions pertain to your birth)

❑Term ❑Premature
❑Pregnancy Complications:_______________________________ ❑Birth Complications:_____________________________
Were you Breast Fed? ❑No ❑Yes, How long?______________ Bottle-fed? ❑No ❑Yes
Age at introduction of: Solid Foods_______ Dairy_______ Wheat_______ Sugar/Candy______ Sugar Often ❑Yes ❑No

MEDICATIONS

Current Medications

Medication	Dose	Frequency	Start Date(month/year)	Reason for Use

Previous Medications- Last 10 Years

Medication	Dose	Frequency	Start Date(month/year)	Reason for Use

Nutritional Supplements- Vitamins, Minerals, Herbs, Homeopathy

Supplement/Brand	Dose	Frequency	Start Date(month/year)	Reason for Use

Have your medications or supplements ever caused you unusual side effects or problems? ❑Yes ❑No
Describe:____

Have you had prolonged or regular use of NSAIDS (Advil, Aleve, etc.), Motrin, Aspirin? ❑Yes ❑No

Have you had prolonged or regular use of Tylenol? ❑Yes ❑No

Have you had prolonged or regular use of Acid Blocking Drugs? (Tagamet, Zantac, Prilosec, etc.) ❑Yes ❑No

Frequent antibiotics > 3 times/year? ❑Yes ❑No

Long term antibiotics? ❑Yes ❑No

Use of steroids (prednisone, nasal allergy inhalers) in the past? ❑Yes ❑No

Use of oral contraceptives ❑Yes ❑No

RH MD
RADIANTLY HEALTHY

FAMILY HISTORY

Check family members that apply	Mother	Father	Brother(s)	Sister(s)	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunts	Uncles	Other
Age (if still alive)												
Age at death (if deceased)												
Cancers												
Colon Cancer												
Breast or Ovarian Cancer												
Heart Disease												
Hypertension												
Obesity												
Diabetes												
Stroke												
Inflammatory Arthritis (Rheumatoid, Psoriatic, Ankylosing Sondylitis)												
Inflammatory Bowel Disease												
Multiple Sclerosis												
Auto Immune Diseases (such as Lupus)												
Irritable Bowel Syndrome												
Celiac Disease												
Asthma												
Eczema / Psoriasis												
Food Allergies, Sensitivities or Intolerances												
Environmental Sensitivities												
Dementia												
Parkinson’s												
ALS or other Motor Neuron Diseases												
Genetic Disorders												
Substance Abuse (such as alcoholism)												
Psychiatric Disorders												
Depression												
Schizophrenia												
ADHD												
Autism												
Bipolar Disease												

SOCIAL HISTORY

NUTRITION HISTORY

Have you ever had a nutrition consultation? ❑Yes ❑No
Have you made any changes in your eating habits because of your health? ❑No ❑Yes, Describe:_________________________
____
Do you currently follow a special diet or nutritional program? ❑Yes ❑No

Check all that apply:
❑Low Fat ❑Low Carbohydrate ❑High Protein ❑Low Sodium ❑Diabetic ❑No Dairy ❑No Wheat
❑Vegetarian ❑Vegan ❑Ultrametabolism

Specific Program for Weight Loss/Maintenance? ❑No ❑Yes, Type:____
Other____

Height (feet/inches)____________
Usual Weight Range +/- 5 lbs____________
Highest adult weight_____________
Weight Fluctuations? (>10 lbs.) ❑No ❑Yes
Current Weight _______________
Desired Weight Range +/- 5 lbs ______________
Lowest adult weight _____________
Body Fat % ______________

How often do you weigh yourself? ❑Daily ❑Weekly ❑Monthly ❑Rarely ❑Never
Have you ever had your metabolism (resting metabolic rate) checked? ❑No ❑Yes, what was it?_________________
Do you avoid any particular foods? ❑ No ❑Yes, Types and Reason? ____
____

If you could only eat a few foods a week, what would they be? ____
____

Do you grocery shop? ❑Yes ❑No, who does the shopping?____
Do you read food labels? ❑Yes ❑No
Do you cook? ❑Yes ❑No, who does the cooking?____
How many meals do you eat out per week? ❑ 0-1 ❑1-3 ❑3-5 ❑>5 meals per week

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

❑Fast eater
❑Erratic eating pattern
❑Late night eating
❑Time constraints
❑Travel frequently
❑Do not plan meals or menus
❑Poor snack choices
❑Don't care to cook
❑Love to eat
❑Have a negative relationship to food
❑Eating in the middle of the night
❑Eat too much under stress
❑Confused about nutrition advice
❑Eat too much
❑Dislike healthy food
❑Eat more than 50% meals away from home
❑Non-availability of healthy foods
❑Reliance on convenience items
❑ Family members don't like healthy foods
❑ Family members have special dietary need/food preferences
❑Eat because I have to
❑Struggle with eating issues
❑Emotional eater (eat when sad, lonely, depressed, bored)
❑Eat too little under stress

The most important thing I should change about my diet to improve my health is:_____________________________________
____
____

SMOKING

Currently Smoking? ❑No ❑Yes, How many years?_____________ Packs per day?______________
Attempts to quit:____
Previous Smoking: How many years?____________________ Packs per day?__________________ Date Quit?________________
Second Hand Smoke Exposure?____

ALCOHOL INTAKE

How many drinks currently per week? (*1 drink = 5 ounces wine, 12 ounces beer, 1.5 ounces spirits)*
❑None ❑1-3 ❑4-6 ❑7-10 ❑>10
Previous alcohol intake? ❑None (*If "None," skip to Other Substances)* ❑Yes(❑Mild ❑Moderate ❑ High)
Have you ever been told you should cut down your alcohol intake? ❑Yes ❑No
Do you get annoyed when people ask you about your drinking? ❑Yes ❑No
Do you ever feel guilty about your alcohol consumption? ❑Yes ❑No
Do you ever take an eye-opener? ❑Yes ❑No
Do you notice a tolerance to alcohol (can you "hold" more than others)? ❑Yes ❑No
Have you ever been unable to remember what you did during a drinking episode? ❑Yes ❑No
Do you get into arguments or physical fights when you have been drinking? ❑Yes ❑No
Have you ever been arrested or hospitalized because of drinking? ❑Yes ❑No
Have you ever thought about getting help to control or stop your drinking? ❑Yes ❑No

OTHER SUBSTANCES

Caffeine Intake: ❑No ❑Yes, Coffee cups/day: ❑1 ❑2-4 ❑>4
Tea cups/day: ❑1 ❑2-4 ❑>4
Caffeinated Sodas or Diet Sodas Intake: ❑No ❑Yes, 12-ounce can/bottle ❑1 ❑2-4 ❑>4 per day
List favorite type (Ex. Diet Coke, Pepsi, etc.):____
____
Are you currently using any recreational drugs? ❑Yes ❑No ❑Type ____
Have you ever used IV or inhaled recreational drugs? ❑Yes ❑No

EXERCISE

Current Exercise Program: (List type of activity, number of sessions/week, and duration)

Activity	Type of Exercise	Times Per Week	Duration in Minutes
Stretching			
Cardio/Aerobics			
Strength			
Other (yoga, pilates, etc).			
Sports/Leisure Activities (golf, tennis, rollerblading, etc.)			

Rate your level of motivation for including exercise in your life? ❑Low ❑Medium ❑High
List problems that limit activity:
Do you feel unusually fatigued after exercise? ❑Yes ❑No
If yes, please describe:____
Do you usually sweat when exercising? ❑Yes ❑No

PSYCHOSOCIAL

Do you feel significantly less vital than you did a year ago? ❑Yes ❑No
Are you happy? ❑Yes ❑No
Do you feel your life has meaning and purpose? ❑Yes ❑No
Do you believe stress is presently reducing the quality of your life? ❑Yes ❑No
Do you like the work you do? ❑Yes ❑No
Have you ever experienced major losses in your life? ❑Yes ❑No
Do you spend the majority of your time and money to fulfill responsibilities and obligations? ❑Yes ❑No
Would you describe your experience as a child in your family as happy and secure? ❑Yes ❑No

STRESS/COPING

Have you ever sought counseling? ❑Yes ❑No
Are you currently in therapy? ❑Yes ❑No Describe:____
Do you feel you have an excessive amount of stress in your life? ❑Yes ❑No
Do you feel you can easily handle the stress in your life? ❑Yes ❑No
Daily Stressors: Rate on scale of 1-10
Work______ Family______ Social______ Finances______ Health______ Other_______
Do you practice meditation or relaxation techniques? ❑No ❑Yes, How often?_______________________
Check all that apply: ❑Yoga ❑Meditation ❑Imagery ❑Breathing ❑Tai Chi ❑Prayer ❑Other:_______________
Have you ever been abused, a victim of a crime, or experienced a significant trauma? ❑Yes ❑No

SLEEP/REST

Average number of hours you sleep per night: ❑>10 ❑8-10 ❑6-8 ❑<6
Do you have trouble falling asleep? ❑Yes ❑No
Do you feel rested upon awakening? ❑Yes ❑No
Do you have problems with insomnia? ❑Yes ❑No
Do you snore? ❑Yes ❑No
Do you use sleeping aids? ❑Yes ❑No Explain:____

ROLES/RELATIONSHIP

Marital Status ❑Single ❑Married ❑Divorced ❑Gay/Lesbian ❑Long Term Partnership ❑Widow
List Children:

Child's Name	Age	Gender	Occupation	Living at Home?

Resources for emotional support?
Check all that apply: ❑Spouse ❑Family ❑Friends ❑Religious/Spiritual ❑Pets ❑Other:
Are you satisfied with your sex life? ❑Yes ❑No

How well have things been going for you?	Very Well	Fine	Poorly	Does Not Apply
Overall				
At school				
In your job				
In your social life				
With close friends				
With sex				
With your attitude				
With your boyfriend/girlfriend				
With your children				
With your parents				
With your spouse				

ENVIRONMENTAL AND DETOXIFICATION ASSESSMENT

Do you have known adverse food reactions or sensitivities? ❑No ❑Yes, describe symptoms:______________________________
____
Do you have any food allergies or sensitivities? ❑No ❑Yes, List all:____
Do you have an adverse reaction to caffeine? ❑Yes ❑No
When you drink caffeine do you feel: ❑Irritable or Wired ❑Aches & Pains

Do you adversely react to (check all that apply):
❑Monosodium Glutamate (MSG) ❑Aspartame (Nutrasweet) ❑Caffeine ❑Bananas ❑Garlic ❑Onion ❑Cheese
❑Citrus Foods ❑Chocolate ❑Alcohol ❑Red Wine ❑Sulfite Containing Foods (wine, dried fruit, salad bars)
❑Preservatives (ex. Sodium benzoate) ❑Other:____

Which of these significantly affects you? Check all that apply:
❑Cigarette Smoke ❑Perfume/Colognes ❑Auto Exhaust Fumes ❑Other:____

In your work or home environment, are you exposed to: ❑Chemicals ❑Electromagnetic Radiation ❑Mold
Have you ever turned yellow (jaundiced)? ❑No ❑Yes
Have you ever been told you have Gilbert's syndrome or a liver disorder? ❑No ❑Yes, Explain: ______________________________
____
Do you have a known history of significant exposure to any harmful chemicals such as the following:
❑Herbicides ❑ Insecticides (frequent visits of exterminator) ❑Pesticides ❑Organic Solvents ❑Heavy Metals
❑Other: Chemical Name, Date, Length of Exposure:____
Do you dry clean your clothes frequently? ❑Yes ❑No
Do you or have you lived or worked in a damp or moldy environment or had other mold exposures? ❑Yes ❑ No
Do you have any pets or farm animals? ❑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 your 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 your 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
Have periodic lab tests to assess your progress………………………❑5 ❑4 ❑3 ❑2 ❑1
Comments ____
____
____

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 your life lead you to question your capacity to fully engage in the above activities?____
____
____

Rate on a scale of 5 (very supportive) to 1 (very unsupportive):
At the present time, how supportive do you think people in your household will be to your implementing the above changed?
❑5 ❑4 ❑3 ❑2 ❑1
Comments____
____
____

Rate on a scale of 5 (very frequent contact) to 1 (very infrequent contact):
How much on-going support and contact (e.g., telephone consults, e-mail correspondence) from our professional staff would be helpful as you implement your personal health program?
❑5 ❑4 ❑3 ❑2 ❑1
Comments____
____
____

3-DAY DIET DIARY INSTRUCTIONS

It is important to keep an accurate record of your usual food and beverage intake as a part of your treatment plan. Please complete this Diet Diary for 3 consecutive days including one weekend day.

- Do not change your eating behavior at this time, as the purpose of this food record is to analyze your present eating habits.
- Record information as soon as possible after the food has been consumed
- Describe the food or beverage as accurately as possible e.g., milk – what kind? (whole, 2%, nonfat); toast (whole wheat, white, buttered); chicken (fried, baked, breaded); coffee (decaffeinated with sugar and ½ & ½).
- Record the amount of each food or beverage consumed using standard measurements such as 8 ounces, ½ cup, 1 teaspoon, etc.
- Include any added items. For example: tea with 1 teaspoon honey, potato with 2 teaspoons butter, etc.
- Record all beverages, including water, coffee, tea, sports drinks, sodas/diet sodas, etc.
- Include any additional comments about your eating habits on this form (ex. Craving sweet, skipped meal and why, when the meal was at a restaurant, etc).
- Please note all bowel movements and their consistency (regular, loose, firm, etc.)

DIET DIARY

Name: ____ Date:________________________________

DAY 1

TIME	FOOD/BEVERAGE/AMOUNT	COMMENTS

Bowel Movements (#, form, color)____

Stress/Mood/Emotions____

Other Comments____

RH MD
RADIANTLY HEALTHY

DAY 2

TIME	FOOD/BEVERAGE/AMOUNT	COMMENTS

Bowel Movements (#, form, color)____

Stress/Mood/Emotions____

Other Comments____

DAY 3

TIME	FOOD/BEVERAGE/AMOUNT	COMMENTS

Bowel Movements (#, form, color)____

Stress/Mood/Emotions____

Other Comments____