

# Health & Lifestyle Assessment

Integritas<sup>®</sup> Medical Institute wants to assure you that all of the information provided below will remain strictly confidential. When providing your contact information, please be aware that these numbers will be used for medically related and financial correspondence only. Thank you.

Date: \_\_\_\_\_

## Contact Information

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Cell: \_\_\_\_\_

Personal Fax: \_\_\_\_\_

Personal Email: \_\_\_\_\_

Business Phone: \_\_\_\_\_

Business Fax: \_\_\_\_\_

Business Email: \_\_\_\_\_

Where do you prefer to be contacted? Mark all options that apply.

- Home
- Cell
- Business

How do you wish to receive our correspondence? Mark all options that apply.

- Phone
- Email
- Fax

Primary Care Physician: \_\_\_\_\_

Office Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Would you like for us to forward information to your doctor?  Yes  No



## Personal Health History

1. When was the last time you went to the doctor for a general check up or an illness?
2. Within the past 12 months, how many times did you see a medical doctor about your health?
3. Which of the following do you do on a regular basis? Check all that apply.
  - Annual dental check ups
  - Annual teeth cleaning
  - Brush your teeth at least twice a day
  - Use dental floss on a daily basis
  - None of the above
4. Comparing your health to others of your age, how would you rate your health?
  - Excellent
  - Good
  - Average
  - Fair
  - Poor
5. During the past year, how many days did you miss from work, or have your regular activities curtailed, due to illness? \_\_\_\_\_
6. In the past 12 months, how many days were you in the hospital? \_\_\_\_\_
7. Do you have an annual rectal exam?       Yes     No
8. Do you have an annual examination for blood in your stool?       Yes     No
9. Please review the list of conditions and check the column(s) that most applies to you and your family history. Leave blank any condition(s) you wish to discuss privately with your Institute Physician.

Condition	Not Applicable	Myself	Sibling	Parents		Grandparents	
				M	F	Maternal	Paternal
Heart Disease							
Cancer							
Diabetes							
High Blood Pressure							
Arthritis							
Liver Disease (i.e. hepatitis, cirrhosis)							
Mental Health Issues (i.e. depression, anxiety, psychotic disorders)							
Autoimmune Disease (lupus, rheumatoid arthritis)							
Endocrine Gland Disorders (thyroid, adrenal, pituitary)							





14. Please describe any current usage of recreational drugs.

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15. Please list any diagnostic procedures you have had. Provide the approximate date, reason for the procedure, and result.

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16. Please list any surgical procedures you have had, including plastic surgery, along with the approximate date.

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17. Please list any history of trauma that you have experienced (i.e. car accidents, head injuries, broken bones).

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18. Have you ever had a blood transfusion?  Yes  No

If so, please list the approximate date(s) and reason(s).

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19. Please indicate if you are currently receiving any of the following.

Radiation Therapy                      Condition: \_\_\_\_\_  
 Chemotherapy                              Condition: \_\_\_\_\_

20. Please provide the date and length of exposure, if any, to the environmental risks listed below.

Exposure	Date(s)	Length of Exposure
Asbestos		
Coal dust		
Chemicals		
Sun/tanning		
Fumes/gasses		
Radon testing		
X-ray treatments		
Other:		

## Review of Overall Health

Under the categories listed below, check the “yes” column **only** if you are experiencing the listed symptom to a **substantial** or **unusual** degree.

### Skin and Hair

Symptom	Yes	No
Dry/brittle and/or flaky hair		
Dry/brittle skin		
Acne		
Age spots		
Thick skin and fingernails		
Puffy, wrinkled skin		
Dark circles under eyes		
Hair thinning or falling out or hair grows very slowly		
Toe or fingernail fungus		
Bumpy skin on face or back of arms		
Spider veins in nose and/or face		
Persistent rash/skin allergy		
Hives		
Sores, boils, or sties		
Slow or poor wound healing		
Excessive sweating or itching		
Flushing or hot flashes		
Bruise easily or excessively		

### Allergies

Allergy	Yes	No
Seasonal allergies—describe symptoms:		
Food allergies—list type & reaction:		
Latex or other environmental allergies—describe reaction:		

## Cardiopulmonary

Symptom	Yes	No
Pain in the left side under the rib cage		
Pain in the right side under the rib cage		
Pain in the left arm		
Chest pain at rest or while walking, running, or lifting weights		
Other pain in chest or sides		
Frequent and recurring upper respiratory infections or colds/flu		
Fluid retention (e.g., swollen ankles, legs, etc.)		
Cannot tolerate much exercise		
Difficulty breathing		
Chronic lung congestion		
Wheezing		
Heaviness in legs		
Calf muscle cramps while walking		
Heart pounds easily		
Heart misses beats or has extra beats		
Rapid heartbeat, fluttering		
Shortness of breath		
Heartburn after eating		
Exhaustion with minor exertion		
Erratic blood pressure		
High blood pressure		
Low blood pressure		
Breathing problems at night		
Difficulty lying flat		

## Metabolic

Symptom	Yes	No
Certain foods cause ill feelings		
Difficulty gaining weight		
Difficulty losing weight		
Bad breath (no relief by brushing)		
Body odor (no relief by washing)		
Total blood cholesterol above 200		
HDL cholesterol below 50		
LDL cholesterol above 130		
Swollen (bulging) eyes		
Hypersensitive to the cold		
Cold hands and feet		
Thinning or loss of outside portion of eyebrow		
Gain weight easily		
Body temperature below 97.6 degrees Fahrenheit		
Crave salt or salty foods		
Blushing with no apparent cause		
Irritable if meal is missed		

Symptom (continued)	Yes	No
Wake up in the middle of the night craving sweets		
Feel tired or weak if meal is missed		
Heart palpitations after eating sweets		
Need to drink caffeine to get going		
Feel tired 1 to 3 hours after eating		
Feel faint or weak		
Night sweats		
Increase thirsts		
Overweight		
Crave sweets (but eating sweets does not relieve symptoms)		
Sugar in urine		
Weight loss of more than 10 lbs. in the last six months		
Weight gain of more than 10 lbs. in the last six months		
Weight has stayed consistent over last five years		

## **Kidney/Bowels/Bladder/Gastrointestinal**

Symptom	Yes	No
Frequent urination or scant urination/dribbling		
Burning during urination		
Loss of bladder control (including leaking)		
Hemorrhoids		
Excessive nighttime urination (specify number of times)		
Loss of bowel control		
Blood in urine		
Blood in stool		
Kidney stones		
Frequent urinary tract infections		
Diarrhea		
Constipation (hard or effortful bowel movements)		
Difficulty urinating		
Abdominal pain		
Nausea and/or vomiting		
Heartburn/reflux		
Difficulty swallowing or pain with swallowing		
Flatulence (gas) or bloating		
Gallbladder problems		
Dependency on Antacids		

## **Neurological**

Symptom	Yes	No
Headaches		
Faintness		
Seizures/convulsions		
Tremors		
Dizziness		

Symptom (continued)	Yes	No
Tingling or numbness		
Balance problems		
Paralysis		
Muscle weakness		
Uncoordinated		
Difficulty walking		
Difficulty speaking		
Memory problems		
Loss of smell or taste		
Problems with attention and concentration		

## Eyes/Ears/Nose/Throat

Symptom	Yes	No
Change in vision		
Blurred or tunnel vision		
Double vision		
Balance problems		
Hearing loss		
Ringing in ears		
Ear pain		
Ear drainage		
Nosebleeds		
Stuffy nose		
Sore throat/hoarseness		
Sinus infections		
Sore or bleeding gums		
Canker sores or cold sores		
Difficulty swallowing		

## Joints/ Muscles/ Bones

Symptom	Yes	No
Joint pain, swelling or stiffness		
Arthritis		
Back pain		
Limited motion		
Muscle tension or spasms		
Fibromyalgia		
Carpal Tunnel Syndrome		

## Mind and Emotions

Symptom	Yes	No
Rapid mood swings		
Impatient, moody, nervous		
Lack of mental alertness		
Depression		
Anxiety/fear		
Lack of self-esteem		
Difficulty with memory, attention, or concentration		
Short attention span		
Personality changes		
Sleep disturbances		
Short temper/anger/irritability		
Excessive worrying		
Suicidal thoughts		
Confusion/poor comprehension		
Difficulty making decisions		
Excessive stress		
Restlessness, hyperactivity, or inability to relax		
Weakness, fatigue, or loss of energy		
Frequent infections		

## Miscellaneous

Symptom	Yes	No
Frequent infections or illness		
Change in appetite		
Fatigue		
Apathy/lethargy		
Lumps in neck, armpits, groin or breast		
Broken bone(s) as an adult		
Insomnia		
Hypersomnia (sleeping too much)		
Sleep Apnea		
Difficulty getting out of bed in the morning		
Other symptoms (please list)		

**For Women ... Go to Page 14**

**For Men ... Continue to Page 12**

## For Men

Symptom	Yes	No
Difficulty maintaining/attaining an erection (or insufficient to maintain penetration)		
Ejaculation causes pain		
Sexual drive under active		
Sexual drive overactive		
Premature ejaculation		
Pain/coldness in genital area		
Infertility		
Varicose veins on scrotum		
Low sperm count		
Discharge from penis		
Lack of early morning erections		
Past or present rash on penis		
Swollen genitals		
Swelling in groin		
Genital sores		
Lump or mass in scrotum		
Jock itch		
Past or present sexually transmitted disease (specify):		

Medication	Yes	No
Do you use Viagra, Cialis, Levitra or any other erectile enhancement drugs? If yes, which one(s) and how often?		
Have they helped you?		
Do you use any other medication for sexual function? If yes, please list and describe results:		
Have you ever used testosterone, HCG, DHEA, or hGH? If yes, which one(s) and when?		

Please provide the most recent date and results for the tests listed below.

Test Dates	Results
Prostate exam	
PSA	
Colonoscopy	
Sigmoidoscopy	
Rectal exam	
Resting EKG	
Stress EKG	
Stress Echo	
Nuclear Stress	
Chest X-ray	
Eye exam/eye pressures	

**For Men ... Go to Page 16**

## For Women

Symptom	Yes	No
Missed periods		
Pelvic or vaginal soreness or pain		
Menstrual pain		
Heavy menstrual bleeding		
Irregular periods		
Infertility		
Hot flashes/night sweats		
Under active sex drive		
Overactive sex drive		
Pre-menstrual syndrome (PMS)		
Monthly weight gain		
Bloating and swelling		
Tender breasts		
Low backache		
Vaginal itching		
Vaginal discharge or sores		
Past or present sexually transmitted disease (specify):		
Dislike of intercourse		
Pain in ovaries		
Water retention		
Craving for sweets		
Sweating throughout the day		
Vaginal dryness		
History of miscarriages		
History of ovarian cysts		
History of uterine cysts/fibroids		
History of endometriosis		
Have you had a hysterectomy? If yes, please provide the date and reason.		
Have you ever taken estrogen, progesterone, testosterone, DHEA, or hGH? If yes, which one(s) and when?		
Date of last menstrual period:		
What form of birth control do you use? Please circle. None      Pill      IUD      Sponge      Diaphragm      Foam Vasectomy      Condoms      Tubal Ligation      Hysterectomy		

Please provide the most recent date and results for the tests listed below.

Test Dates	Results
Pap smear	
Pelvic exam	
Breast exam	
Mammogram	
Colonoscopy	
Sigmoidoscopy	
Rectal exam	
Resting EKG	
Stress EKG	
Stress Echo	
Nuclear Stress	
Chest X-ray	
Eye exam/eye pressures	

## Lifestyle Summary

1. How many servings of an alcoholic beverage do you consume in an average week? Note: A serving is defined as a 12-ounce beer, 5-ounce glass of wine, or 1.5 ounces of liquor.

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### For Present and Past Tobacco Users:

2. Do you currently use tobacco?  Yes  No

If yes, what type? (Check all that apply)

- |  |                         |
|--|-------------------------|
| <input type="checkbox"/> Cigarettes      | How many per day? _____ |
| <input type="checkbox"/> Pipe            | How much per day? _____ |
| <input type="checkbox"/> Snuff           | How much per day? _____ |
| <input type="checkbox"/> Cigars          | How many per day? _____ |
| <input type="checkbox"/> Chewing tobacco | How much per day? _____ |

3. If you previously used tobacco, what type did you use? (Check all that apply)

- |  |                                    |
|--|------------------------------------|
| <input type="checkbox"/> Cigarettes      | How many per day on average? _____ |
| <input type="checkbox"/> Pipe            | How much per day on average? _____ |
| <input type="checkbox"/> Snuff           | How much per day on average? _____ |
| <input type="checkbox"/> Cigars          | How many per day on average? _____ |
| <input type="checkbox"/> Chewing tobacco | How much per day on average? _____ |

4. How long did you use tobacco? \_\_\_\_\_

5. When did you quit? \_\_\_\_\_

6. How many times have you quit? \_\_\_\_\_

7. What are your hobbies? \_\_\_\_\_

8. Do you travel outside the country?  Yes  No

If yes, please list the countries you have visited in the last 5 years:

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9. Do you consider yourself to be under a great deal of stress?  Yes  No

If yes, please explain.

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10. Do you use a seat belt?

- Always
- Most of the time
- Sometimes
- Never

11. Do you have a working smoke detector?  Yes  No

12. Do you have a working carbon monoxide detector?  Yes  No

## Exercise Summary

1. On a regular basis, over the last 3 months, indicate the number of days per week you performed the following activities.
  - a. Aerobic exercises (swimming, walking, jogging, cycling, stationary bike) \_\_\_\_\_
  - b. Structured resistance training exercises \_\_\_\_\_
  - c. Structured strength building (strenuous calisthenics) \_\_\_\_\_
  - d. Structured stretching exercises, either alone or with an exercise program \_\_\_\_\_
  - e. Strength building sports, such as gymnastics, martial arts, wrestling \_\_\_\_\_
  - f. Hard physical labor for at least one hour per day (i.e. lifting, pushing, heavy tool operation) \_\_\_\_\_
  - g. Strenuous housework \_\_\_\_\_
  - h. Gardening, including strenuous digging \_\_\_\_\_
2. If you do aerobic exercise, how long is your average workout? \_\_\_\_\_
3. What is the intensity of your aerobic exercise?

<input type="checkbox"/> Very Light	Stretching
<input type="checkbox"/> Light	Includes some movement as in leisure walking
<input type="checkbox"/> Moderate	Continuous movement causing increase in heart rate (brisk walking, leisure swimming)
<input type="checkbox"/> Heavy	Continuous movement involving fluctuation in intensity from moderate to heavy with significant increases in heart rate
<input type="checkbox"/> Very heavy	Continuous movement causing heaving breathing, sweating, marked increases in heart rate, etc. (swimming laps, interval training, running, cycling, stationary bike, spin cycling, etc.)

4. Do you walk, jog, or run on a regular basis?  Yes  No
  - a. If yes, how many times per week? \_\_\_\_\_
  - b. What is the average number of miles per workout? \_\_\_\_\_

5. During the last year, have you experienced any injuries?  Yes  No

a. If yes, please describe your injury?

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b. Did this injury occur as a result of exercising?  Yes  No

c. Did this injury cause you to modify or stop your exercise regimen?  Yes  No

d. If yes, for what period of time did you stop exercising? \_\_\_\_\_

6. Please describe your current aerobic exercise program. Include type, duration, and intensity.

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7. Please describe your current flexibility and/or stretching program (i.e. yoga, tai chi, stretching and toning classes, martial arts, brief stretching after aerobics or weights) Include type and duration.

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8. Please describe your current resistance/strength training exercise program i.e. free weights, weight machines, body pump classes, water aerobics, etc. (discuss type, duration, intensity).

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## Fitness Activity Assessment

Question	Yes	No
Do you enjoy exercising?		
Have you ever been a member of a health club? If yes, for how long?		
Are you currently a member of a health club?		
Have you ever worked with a personal trainer? If yes, for how long?		
Did you enjoy it?		
Are you still with a personal trainer?		
Do you have any exercise equipment at home (bike, treadmill, free weights, etc.)? If yes, please list:		
Are you presently receiving physical therapy? If yes, please describe:		
If exercise is not part of your weekly routine, please explain the reasons.		

## Personal Assessment & Stress Management

1. During the past month, what percent of the time would you say you wake up feeling fresh and fully rested?
  
2. The list below contains several traits that describe people. Select the answer that best describes you. Select only one response for each trait.

	Definitely not me	Somewhat like me	Much like me	Very much like me
Have a need to excel in mostly everything	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Always rushed or pressed for time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eat most meals too fast	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hard driven and competitive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bossy and domineering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. When you are very angry or upset about something, rate each response according to the likelihood of having the listed reaction.

	Not too likely	Somewhat likely	Very likely
Take a few breaths and talk it out	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Act like nothing is wrong or that nothing has happened	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Blame it on someone else (it's never your fault)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Apologize even if you are right	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Take it out on someone else	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Talk it out with someone such as a friend or relative	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Get it out in the open (off your chest)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Keep it to yourself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

4. On an average workday, how do you generally feel? If you are a homemaker, refer to your household duties; if you are unemployed, think back to your last position.
  - a. Often feel inadequate or unsure of your performance  Yes  No
  - b. Often feel "stretched to the max" with your duties  Yes  No
  - c. Often feel pressured or very pressed for time  Yes  No
  - d. Often times feel like work follows you home  Yes  No

5. In general, do you get upset if you have to wait for something?  Yes  No

6. How well do you feel you are able to manage stress?

- Excellent
- Good
- Average
- Fair
- Poor

7. On an average, how many hours of restful sleep do you get per night? \_\_\_\_\_  
How many hours of sleep do you think you need? \_\_\_\_\_

8. Do you take medications or alcohol to help you relax or to change your mood?

Yes If so, how often? \_\_\_\_\_  No

9. From the list, select all the methods you use to relieve tension and/or stress:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Read                       | <input type="checkbox"/> Meditate                | <input type="checkbox"/> Do nothing             |
| <input type="checkbox"/> Listen to music/play music | <input type="checkbox"/> Blow up                 | <input type="checkbox"/> Turn to faith/pray     |
| <input type="checkbox"/> Smoke cigarettes/pip e     | <input type="checkbox"/> Eat                     | <input type="checkbox"/> Take a drug            |
| <input type="checkbox"/> Sleep                      | <input type="checkbox"/> Exercise or walk        | <input type="checkbox"/> Go for a drive         |
| <input type="checkbox"/> Watch television           | <input type="checkbox"/> Don't think about it    | <input type="checkbox"/> Call a friend/relative |
| <input type="checkbox"/> Cry                        | <input type="checkbox"/> Work/Housework          | <input type="checkbox"/> Draw/paint/hobby       |
| <input type="checkbox"/> Throw things               | <input type="checkbox"/> Have an alcoholic drink |   |

10. Do you experience any of the following symptoms when under stress? (Select all that apply):

- |  |                                       |   |
|--|---------------------------------------|---|
| <input type="checkbox"/> Inability to sleep          | <input type="checkbox"/> Chest pain   | <input type="checkbox"/> Nervousness            |
| <input type="checkbox"/> Upset stomach               | <input type="checkbox"/> Irritability | <input type="checkbox"/> None of these symptoms |
| <input type="checkbox"/> Other <i>please explain</i> |                                       |   |

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11. How close are your ties to your family and friends?

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## HOLMES-RAHE LIFE CHANGES SCALE

Please review the events below. Beside each one, indicate the number of times each event occurred in the past year only.

Event	Number of times in past year
Death of a spouse	
Divorce	
Marital separation	
Law suits	
Jail term	
Death of a close family member	
Personal injury or illness	
Marriage	
Fired from work	
Marital reconciliation	
Retirement	
Change in health of a family member	
Pregnancy	
Sexual difficulties	
Gain of a new family member	
Business readjustment	
Change in financial state	
Death of a close friend	
Change to a different line of work	
Change in number of arguments with spouse	
Mortgage over \$500,000	
Foreclosure of mortgage or loan	
Change in responsibilities at work	
Son or daughter leaving home	
Trouble with in-laws	
Outstanding personal achievement	
Spouse began or stopped work	
Began or ended school	
Change in living conditions	
Revision of personal habits	
Trouble with the boss	
Change in work hours or conditions	
Change in residence	
Change in schools	
Change in recreation	
Change in exercise program	
Change in social activities	
Change in sleeping habits	
Change in number of family get-togethers	
Change in eating habits	
Vacations	
Religious holidays	
Minor violations of the law	
Major violations of the law	

Holmes & Rahe (1967), Holmes-Rahe life changes scale. *Journal of Psychosomatic Research*, Vol. 11, pp. 213-218.

## Nutritional Summary

Question	Yes	No
Over the years, have you noticed an increased sensitivity to sweets or white flour foods resulting in increased irritability, tiredness, or depression?		
Are you preoccupied with certain foods and the thought of food?		
Has your eating ever interfered with any part of your life?		
Do you keep your feelings about food and eating a secret?		
Has your weight gone up and down over the years?		
Have you ever lied about how much sweet food or other carbs you eat?		
Is it possible to “just say no” to sweet foods and other processed carbohydrates?		
Are sugar/carbs controlling your life?		
Have you had short-term success in controlling your eating only to slip back into uncontrollable, excessive eating of the foods you are trying to avoid?		
Do you continue to binge despite its adverse consequences on your life and health?		
Are you a vegetarian? If yes, what type?  <input type="checkbox"/> Vegan (plant products only) <input type="checkbox"/> Lactovegetarian (plant and dairy products) <input type="checkbox"/> Ovolactovegetarian (plant, dairy and egg products) <input type="checkbox"/> Fruitarian (fruits, nuts, honey, and vegetables only)		

1. How many cups of tea do you drink per day? \_\_\_\_\_
2. How many cups of coffee do you drink per day? \_\_\_\_\_
3. How many diet sodas or other drinks with aspartame do you drink per day? \_\_\_\_\_
4. How many 8 oz. glasses of water do you drink per day? \_\_\_\_\_
5. How many high sugar foods do you eat per day (i.e. cakes, cookies, breads, pasta)?  
\_\_\_\_\_

## Current Nutritional Intake

In order to accurately assess your current nutrient intake, we need to understand your current eating habits. Please fill out the following nutritional summary in detail for what you consider your average healthy eating day and most unhealthy eating day. This will give us an idea of your strengths and weaknesses and enable us to make suggestions for positive change. List the foods and portions you eat, not those you plan to eat.

- Be specific with portion sizes. If you don't know how many ounces or cups something is, give us a reference. For example: 1 large apple (baseball sized), broiled chicken (about the size of two decks of cards).
- Include any extras you may consume, such as cream or sugar in your coffee, after dinner mints, nibbles of baked goods, candy, etc.
- Don't forget to list beverages (*Diet Coke*, coffee, water, green tea, etc.).

## Healthiest Day

Meal/Snack (Time)	Food	Portion size or estimation	Leave blank for our comments
<b>Breakfast</b> Time: _____			
<b>AM Snack</b> Time: _____			
<b>Lunch</b> Time: _____			
<b>Midday Snack</b> Time: _____			
<b>Dinner</b> Time: _____			
<b>PM Snack</b> Time: _____			
<b>Before Bed Snack</b> Time: _____			

## Most Unhealthy Day

Meal/Snack (Time)	Food	Portion size or estimation	Leave blank for our comments
<b>Breakfast</b> Time: _____			
<b>AM Snack</b> Time: _____			
<b>Lunch</b> Time: _____			
<b>Midday Snack</b> Time: _____			
<b>Dinner</b> Time: _____			
<b>PM Snack</b> Time: _____			
<b>Before Bed Snack</b> Time: _____			

Please note any specific problem foods you consistently overeat, including the frequency (i.e. daily, weekly, or monthly).

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Note situations, moods, or occasions that cause you to eat or drink more than you should.

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