FirstLine Therapy®: Therapeutic Lifestyle Program

On behalf of the staff and practitioners at Dover Women's Health, P.A., we are excited about your interest in the FirstLine Therapy® program. This 12-week program consists of 6 office visits, which will provide you with the knowledge and support you need to make healthy lifestyle choices. You will be given the most up to date research on nutrition, supplements, exercise and mind-body therapies. We will help you create and implement your structured, individualized lifestyle plan through the supervision of our qualified practitioners.

Enclosed is a FirstLine Therapy® brochure that simply outlines the goals and principles of this therapeutic lifestyle program and an information sheet on Bioelectric Impedance Analysis, which is a test that is done throughout the program. Also enclosed is the FirstLine Therapy® Health History form, Health Profile form and Diet/Exercise form. **Please complete these forms and bring them with you to your initial appointment.**

For clinical program details feel free to contact our Lifestyle Educator, Amy Richards, R.N., at (603)-742-2424.

If not covered by your insurance, the cost of the program is outlined on the enclosed Contract for FirstLine Therapy® Visits. Please review this information and bring the signed contract with you to your first appointment. You may contact our billing representatives at (603)-742-2424 with any questions.

Due to the length of these sessions please provide a minimum 24- hour cancellation notice.

Thank you!

700 Central Avenue Dover NH 03820 Phone (603) 742-2424 Fax (603) 742-1763 www.doverwomenshealth.com

DOVER WOMEN'S HEALTH
PROFESSIONAL ASSOCIATION

Measurements

and

Body Composition Testing

At your initial and subsequent visits we will be taking some measurements to obtain baseline and subsequent objective data. This helps us track your progress throughout the program. Each time you come you will have your weight and blood pressure taken and your waist and hips measured. In addition you will have a bioimpedance analysis.

Bioimpedance analysis (BIA) is a reliable, painless method of measuring body composition; including body fat and lean body mass. Measurements are taken with a bioimpedance analyzer, which uses electrodes similar to ECG electrodes. The machine passes a harmless, ultra-low level of electrical current through the body. Lean tissue, which is over 70% water, is a good conductor of electrical current. Fatty tissue-low in water, is not. Thus, the resistance to the flow of electrical current measured by the analyzer can be used to calculate body composition.

Participants will need to remove their right shoe and sock or stocking. The electrodes are placed on the right hand and foot while the individual is lying on an exam table. This whole procedure takes only a few minutes and a computer prints out the results which will be reviewed with you.

Please call if you have any questions or concerns.

Current Diet and Exercise Patterns

Name ______________________ **DOB** __________ **Date** ______________

Obtaining insight into your current diet and exercise patterns will assist the Lifestyle Educator in partnering with you to develop your individualized lifestyle program. **Please take a few moments to complete the information below and bring with you to your initial appointment.**

Breakfast Time: _______

Food choice items, including estimated size/amount of item:

____

____

____

Morning snack, if any: ______________________________

Lunch Time: ________

Food choice items, including estimated size/amount of item:

____

____

____

Afternoon snack, if any: ______________________________

Dinner Time: __________

Food choice items, including estimated size/amount of item:

____

____

____

Evening snack, if any: ______________________________

Alcohol intake, if any: ____________________ Daily water intake: ____________ ounces

If you currently exercise, what is your routine? Include type of exercise, duration and intensity:

____

____

Do you have any exercise limitations? ______________________________

Any additional information: ______________________________

Thanks!!!

Health History

Name ______________________________ Date ____________

Address ______________________________ City ____________ State ______ Zip Code ____________

Phone ______________________________ Email ______________________________

Occupation ______________________________ Age ______ Height ______ Sex ______ Number of Children ______

Marital Status: ☐ Single ☐ Partner ☐ Married ☐ Separated ☐ Divorced ☐ Widow(er)

Are you recovering from a cold or flu? ____________ Are you pregnant? ____________

Reason for office visit ______________________________ Date began ____________

List current health problems for which you are being treated: ______________________________

What types of therapies have you tried for these problem(s) or to improve your health overall:

☐ Diet modification ☐ Fasting ☐ Vitamins/minerals ☐ Herbs ☐ Homeopathy ☐ Chiropractic ☐ Acupuncture ☐ Conventional drugs

☐ Other ______________________________

Do you experience any of these general symptoms on a regular basis?

☐ Debilitating fatigue	☐ Shortness of breath	☐ Insomnia	☐ Constipation	☐ Chronic pain/inflammation
☐ Depression	☐ Panic attacks	☐ Nausea	☐ Fecal incontinence	☐ Bleeding
☐ Disinterest in sex	☐ Headaches	☐ Vomiting	☐ Urinary incontinence	☐ Discharge
☐ Disinterest in eating	☐ Dizziness	☐ Diarrhea	☐ Low grade fever	☐ Itching/rash

Current medications (prescription or over-the-counter): ______________________________

Laboratory procedures performed (e.g., stool analysis, blood and urine chemistries, hair analysis):

____

Outcome: ______________________________

Major hospitalization, surgeries, injuries. Please list all procedures, complications (if any), and dates:

Year	Surgery, illness, or injury	Outcome

Circle the level of stress you are experiencing on a scale of 1 to 10 (1 being the lowest): 1 2 3 4 5 6 7 8 9 10

Identify the major causes of stress (e.g., changes in job, residence or finances): ______________________________

Do you consider yourself: ☐ Underweight ☐ Overweight ☐ Healthy weight Your weight today: ____________

Have you had an unintentional weight loss or gain of 10 pounds or more in the last three months? ____________

Is your job associated with potentially harmful chemicals (e.g., pesticides, radioactivity, solvents) and/or life threatening activities (e.g., firefighter, police officer, etc.)?

____

What are your current health goals: ______________________________

Medical History
- ☐ Arthritis
- ☐ Allergies/hay fever
- ☐ Asthma
- ☐ Alcoholism
- ☐ Alzheimer's disease
- ☐ Autoimmune disease
- ☐ Blood pressure problems
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chronic fatigue syndrome
- ☐ Carpal tunnel syndrome
- ☐ Cholesterol, elevated
- ☐ Circulatory problems
- ☐ Colitis
- ☐ Dental problems
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticular disease
- ☐ Drug addiction
- ☐ Eating disorder
- ☐ Epilepsy
- ☐ Emphysema
- ☐ Eyes, ears, nose, throat problems
- ☐ Environmental sensitivities
- ☐ Fibromyalgia
- ☐ Food intolerance
- ☐ Gastroesophageal reflux disease
- ☐ Genetic disorder
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart disease
- ☐ Infection, chronic
- ☐ Inflammatory bowel disease
- ☐ Irritable bowel syndrome
- ☐ Kidney or bladder disease
- ☐ Learning disabilities
- ☐ Liver or gallbladder disease (stones)
- ☐ Mental illness
- ☐ Mental retardation
- ☐ Migraine headaches
- ☐ Neurological problems (Parkinson's, paralysis)
- ☐ Sinus problems
- ☐ Stroke
- ☐ Thyroid trouble
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Sexually transmitted disease
- ☐ Seasonal affective disorder
- ☐ Skin problems
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Urinary tract infection
- ☐ Varicose veins

Other ____________

Medical (Men)
- ☐ Benign prostatic hyperplasia
- ☐ Prostate cancer
- ☐ Decreased sex drive
- ☐ Infertility
- ☐ Sexually transmitted disease

Other ____________

____

Medical (Women)
- ☐ Menstrual irregularities
- ☐ Endometriosis
- ☐ Infertility
- ☐ Fibrocystic breasts
- ☐ Fibroids/ovarian cysts
- ☐ Premenstrual syndrome (PMS)
- ☐ Breast cancer
- ☐ Pelvic inflammatory disease
- ☐ Vaginal infections
- ☐ Decreased sex drive
- ☐ Sexually transmitted disease

Other ____________

Date of last GYN exam ____________

Mammogram ☐ + ☐ -

PAP ☐ + ☐ -

Form of birth control ____________

# of children ____________

# of pregnancies ____________

☐ C-section ____________

Age of first period ____________

Date of last menstrual cycle ____________

Length of cycle ____________ days

Interval of time between cycles ____________ days

Any recent changes in normal menstrual flow (e.g., heavier, large clots, scanty) _

- ☐ Surgical menopause
- ☐ Menopause

Family Health History (Parents and Siblings)
- ☐ Arthritis
- ☐ Asthma
- ☐ Alcoholism
- ☐ Alzheimer's disease
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Drug addiction
- ☐ Eating disorder
- ☐ Genetic disorder
- ☐ Glaucoma
- ☐ Heart disease
- ☐ Infertility
- ☐ Learning disabilities
- ☐ Mental illness
- ☐ Mental retardation
- ☐ Migraine headaches
- ☐ Neurological disorders (Parkinson's, paralysis)
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Stroke
- ☐ Suicide

Other ____________

____

Health Habits
☐ Tobacco:

Cigarettes: # /day ____________

Cigars: # /day ____________

☐ Alcohol:

Wine: # glasses/d or wk ____________

Liquor: # ounces/d or wk ____________

Beer: # glasses/d or wk ____________

☐ Caffeine:

Coffee: # 6 oz cups/d ____________

Tea: # 6 oz cups/d ____________

Soda w/caffeine: # cans/d ____________

Other sources ____________

☐ Water: # glasses/d ____________

Exercise
- ☐ 5-7 days/wk
- ☐ 3-4 days/wk
- ☐ 1-2 days/wkk
- ☐ 45 minutes or more durat on per workout
- ☐ 30-45 minutes duration per workout
- ☐ Less than 30 minutes
- ☐ Walk: #days/wk ____________
- ☐ Run, jog, other aerobic - #days/wk ____________
- ☐ Weight lift: #days/wk ____________
- ☐ Stretch: #days/wk ____________

Other ____________

Nutrition & Diet
- ☐ Mixed food diet (animal and vegetable sources)
- ☐ Vegetarian
- ☐ Vegan
- ☐ Salt restriction
- ☐ Fat restriction
- ☐ Starch/carbohydrate restriction
- ☐ The Zone Diet
- ☐ Total calorie restriction

Specific food restrictions:

☐ dairy ☐ wheat ☐ eggs

☐ soy ☐ corn ☐ all gluten

Other ____________

Food Frequency
Number of servings per day:

Fruits (citrus, melons, etc.) ____________

Dark green or deep yellow/orange vegetables ____________

Grains (unprocessed) ____________

Beans, peas, legumes ____________

Dairy, eggs ____________

Meat, poultry, fish ____________

Eating Habits
- ☐ Skip meals (which ones) ____________
- ☐ One meal/day
- ☐ Two meals/day
- ☐ Three meals/day
- ☐ Graze (small frequent meals)
- ☐ Generally eat on the run
- ☐ Eat constantly whether hungry or not

Current Supplements
- ☐ Multivitamin/mineral
- ☐ Vitamin C
- ☐ Vitamin E
- ☐ EPA/DHA
- ☐ Evening primrose/GLA
- ☐ Calcium, source ____________
- ☐ Magnesium
- ☐ Zinc
- ☐ Minerals (describe) ____________
- ☐ Friendly flora (acidophilus)
- ☐ Digestive enzymes
- ☐ Amino acids
- ☐ CoQ10
- ☐ Antioxidants (e.g., lutein, resveratrol)
- ☐ Herbs
- ☐ Homeopathy
- ☐ Protein shakes
- ☐ Superfoods (e.g., bee pollen, phytonutrient blends)
- ☐ Liquid meals

Other ____________

I Would Like to:

Energy, Vitality
- ☐ Feel more vital
- ☐ Have more energy
- ☐ Have more endurance
- ☐ Be less tired after lunch
- ☐ Sleep better
- ☐ Be free of pain
- ☐ Get less colds and flu
- ☐ Get rid of allergies
- ☐ Not be dependent on over-the-counter medications like aspirin, ibuprofen, antihistamines, sleeping aids, etc.
- ☐ Stop using laxatives and stool softeners
- ☐ Improve sex drive

Body Composition
- ☐ Lose weight
- ☐ Burn more body fat
- ☐ Be stronger
- ☐ Have better muscle tone
- ☐ Be more flexible

Stress: Mental and Emotional
- ☐ Learn how to reduce stress
- ☐ Think more clearly and be more focused
- ☐ Improve memory
- ☐ Be less depressed
- ☐ Be less moody
- ☐ Be less indecisive
- ☐ Feel more motivated

Life Enrichment
- ☐ Reduce my risk of degenerative disease
- ☐ Slow down accelerated aging
- ☐ Maintain a healthier life longer
- ☐ Change from a "treating-illness" orientation to creating a wellness lifestyle

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Health Profile Questionnaire

Name ______________________ Date ______________

Rate each of the following symptoms based on how you've been feeling for the: ☐ Past 48 hours ☐ Past Week ☐ Past 30 days

Point Scale
- 0 — Never or almost never have the symptoms
- 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

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 farsightedness)

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 or 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 ______

Lungs
- ______ Chest congestion
- ______ Asthma, bronchitis
- ______ Shortness of breath
- ______ Difficulty breathing

Total ______

Digestive Tract
- ______ Nausea, vomiting
- ______ Diarrhea
- ______ Constipation
- ______ Bloated feeling
- ______ Belching, passing gas
- ______ Heartburn
- ______ Intestinal/stomach pain

Total ______

Joints/ Muscles
- ______ 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 ________

FirstLine Therapy

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