Patient Introduction Form

Name: _____ _____ _____
First Middle Last

Date of Birth: _____ Age:_____ Gender: □Male □Female

Highest Education Level: □ Less than high school □ Under graduate

□ High Schools □ Postgraduate

Genetic Make-up:

□ Caucasian
□ Asian
□ Hispanic
□ Middle Eastern
□ Other _____

□ African
□ Native American
□ Mediterranean
□ Ashkenazi

Occupation: _____

Home Address: _____
Number, street

_____
City State Zipcode

Home Phone: _____ Cell phone: _____

Work phone: _____ Email: _____

Emergency Contact Name: _____

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Relationship: _____ Phone: _____ Email: _____

Address: _____
Number, street

_____
City State Zipcode

Primary Care Doctor Name: _____

Phone number:_____ Fax number: _____

Please list all allergies related to food, supplements or medications as well as the type of allergic reaction.

1. _____ Reaction: _____
2. _____ Reaction: _____
3. _____ Rection: _____

Main concern

What is the main concern that you would like to be addressed during this visit?

_____

What prior treatments or strategies have you used to treat this concern and if any of the treatments were helpful?

_____

_____

_____

_____

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Past Medical History

Patient's Birth History

□ Premature □ Term	□ Bottle fed □ Breast fed, How long? _____
□ Vaginal delivery □ C-section	Age at introduction of solid foods _____

Pregnancy Complications: _____

Birth complications: _____

Childhood illness: _____

Environmental and Detox assessment

Do you have intolerance or adverse reaction or sensitivity towards any of the following? Specify the symptoms or reaction that you experience after exposure to these

□ Caffeine _____	□ Perfumes/ Cologne _____
□ Alcohol _____	□ Paint fumes
□ Saturated Fats _____	□ Exhaust fumes
□ Preservatives (e.g. Sodium Benzoate) _____	□ Sulfite containing foods (wine, dried fruit, salad bar) _____
□ Onion _____	□ Garlic _____
□ Banana _____	□ Chocolate _____

□ Cheese _____	□ Citrus foods _____
□ Aspartame (NutraSweet)_____	□ MSG (Monosodium Glutamate) _____
Any other food intolerance or sensitivity? _____	

Have you ever been exposed to any of the following?

□ Tick	□ Chemicals	□ Electromagnetic radiation
□ Mold	□ Herbicides	□ Pesticides
□ Insecticides (frequent exterminator visits)	□ organic solvents	□ Heavy metals
□ Dry cleaning clothes frequently	□ Other	

Do you have pets or farm animals? □ Yes □ No

Any history of foreign travel? □ Ye □ No If yes Where: _____

History of frequent camping in woods or gardening? □ Yes □ No

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<u>Dental History</u>

Do you have any of the following?

□ Silver Mercury Fillings How many? _____ □ Gold fillings
□ Root canals □ teeth implants
□ tooth pain □ bleeding gums
□ Gingivitis □ Difficulty chewing food
□ Other _____

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Have you ever been diagnosed with any of the following diseases or health conditions?

Digestive System □ Irritable Bowel Syndrome □ Inflammatory Bowel Disease □ Crohn's Disease □ Ulcerative Colitis □ Gastritis □ Peptic Ulcer Disease □ GERD (Reflux) □ Celiac Disease □ Fatty liver disease □ Other _____	Hormonal Diseases □ Type 1 Diabetes □ Type 2 Diabetes □ Pre diabetes □ Low blood sugar □ Hypothyroidism □ Hyperthyroidism □ Infertility □ Polycystic Ovary Disease □ Anorexia □ Bulimia or binge eating □ Night eating syndrome □ Other_____
Respiratory Disease □ Allergic Rhinitis □ Sinusitis □ Bronchitis □ Asthma □ Emphysema □ Sleep apnea □ Pneumonia □ Tuberculosis □ Pulmonary embolism (clot in the lungs) □ □ Other_____	Heart and Blood Vessel Disease □ Angina □ Heart Attack □ Heart Failure □ Irregular heart rate □ High cholesterol □ High blood pressure □ Stroke □ Rheumatic fever □ Heart valve malfunction □ Other_____
Cancer □ Breast cancer □ Cervical cancer □ Cervical dysplasia □ Ovarian cancer □ Prostate cancer □ Lung Cancer □ Colon cancer □ Skin Cancer □ Other _____	Kidney and Genital Disease □ Chronic kidney Disease □ Kidney stones □ Interstitial cystitis □ Frequent urinary infections □ Frequent yeast infection □ Genital herpes □ History of sexually transmitted disease such as Chlamydia or Gonorrhea □ Other_____

Autoimmune Disease □ Lupus (SLE) □ Rheumatoid arthritis □ Chronic Fatigue Syndrome □ Multiple Chemical Sensitivities □ Food allergies □ Environmental allergies □ Immune deficiency Disease □ Recurrent infections □ Severe infections □ Other_____	Neurological Disease □ Anxiety □ Depression □ Bipolar Disorder □ Schizophrenia □ ADD/ADHD □ Post traumatic Stress Disorder (PTSD) □ Autism □ Headaches □ Migraine □ Seizures □ Multiple Sclerosis □ Parkinson's Disease □ Memory problems □ Cognitive Impairment □ ALS □ Other_____
Skin □ Eczema □ Psoriasis □ Acne □ Melanoma □ Rash □ Other_____	Muscle, Bone and Joint Disease □ Osteoarthritis □ Fibromyalgia □ Back pain □ Joint pain □ Osteoporosis □ Other_____
Men's Health □Decreased libido □ Difficulty obtaining erection □ Difficulty maintaining erection □ Elevated PSA □ Prostate enlarged □ Prostate infection □ Loss of urine control □ Urination at night □ Difficulty starting urination □ Weak or slow urinary stream □ Urgency to urinate □ Incomplete bladder emptying □ Other_____	Women's Health □ High blood pressure during pregnancy □ PMS □ Gestational Diabetes □ Postpartum depression □ Fibrocystic breast disease □ Hot flashes □ Mood swings □ Vaginl dryness □ Decreased libido □ Heavy bleeding □ Loss of urine control □ urgency to urinate □ Other_____
□ Head injury □ Back injury □ Bone fracture _____	

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□ Neck injury	□ Car accident	□ Joint injury	_____

Tests and Screenings Have you had any of the following tests? If so please provide the dates.		Past Surgical History Have you had any of the following surgeries? If so please provide the dates	
□ Complete physical	_____	□ Removal of Appendix	_____
□ EKG	_____	□ Removal of uterus	_____
□ Heart stress test	_____	□ Removal of ovaries	_____
□ Echo	_____	□ Removal of Gallbladder	_____
□ Ultrasound	_____	□ Removal of bowels	_____
□ CT Scan	_____	□ Hernia surgery	_____
□ MRI	_____	□ Tonsils removal	_____
□ Mammogram	_____	□ Joint replacement	_____
□ Breast thermography	_____	□ Heart surgery/bypass	_____
□ Pap smear	_____	□ Heart valve surgery	_____
□ Bone Scan/ Dexa	_____	□ Heart stent	_____
□ stool test for blood	_____	□ Heart cath/ angioplasty	_____
□ Colonoscopy	_____	□ Pacemaker	_____
□ Upper GI endoscopy	_____	□ Dental surgery	_____
□ X-ray	_____	□ Sinus surgery	_____
□ Other	_____	□ Other	_____

Have you ever been hospitalized? □ No If yes, specify the dates and reasons

_____

_____

_____

_____

Women's Health

Age at first period ____ Menses □ regular □ irregular □ Clotting □ Menopause

Have you ever used □ Birth control pill □ Patch □ Nuva Ring □ IUD

Number of □ Pregnancies _____ □ Miscarriages _____ □ Abortions _____

Did you breastfeed? □ Yes □ No If yes, how long _____ months

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Symptom Review:

Please check all symptoms that you have or had in last 6 months

General	□ Carbohydrate craving (bread, pasta)	□ Difficulty swallowing
□ Cold hands & feet	□ Sweet cravings (candies, cookies, cakes)	□ Dry mouth
□ Cold intolerance	□ Chocolate Cravings	□ Excess Flatulence/ Gas
□ Daytime sleepiness	□ Caffeine Dependency	□ Fissures
□ Difficulty falling asleep	**Digestion**	□ Foods "repeat" (reflux)
□ Early waking	□ Sore tongue	□ Heartburn
□ Fatigue	□ Anal spasms	□ Hemorrhoids
□ Fever	□ Bad teeth	□ Intolerance to Lactose
□ Flushing	□ Bleeding gums	□ Intolerance to all milk products
□ Heat intolerance	□ Bloating of Lower abdomen	□ Intolerance to Gluten (wheat)
□ Night waking	□ Bloating of whole abdomen	□ Intolerance to Corn
□ Nightmares	□ Blood in stools	□ Intolerance to Eggs
□ No dream recall	□ Burping	□ Intolerance to yeast
□ Low blood pressure	□ Canker sores	□ Liver disease/jaundice (yellow eyes or skin)
Eating	□ Cold sores	□ Abnormal liver test
□ Binge eating	□ Constipation	□ Lower abdominal pain
□ Frequent dieting	□ Cramping	□ Mucus in stools
□ Can't gain weight	□ Cracking at corner of lips	□ Strong stool odor
□ Can't lose weight	□ Dentures w/poor chewing	□ Undigested food in stools
□ Carbohydrate craving	□Diarrhea	□ Blood in stool
□ Carbohydrate intolerance	□ Alternating Diarrhea and Constipation	**Head, Eyes & Ears**
□ Poor appetite	□ Upper abdominal pain	□ Conjunctivitis
□ Salt craving	□ Vomiting	□ Distorted sense of smell

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□ Nausea	□ Indigestion	□ Distorted taste
□ Ear fullness	□ Tendonitis	□ Visual hallucinations
□ Ear pain	□Tension Headache	**Skin**
□ Ear ringing/buzzing	□TMJ Problems	□ Acne on back
□ Eye crusting	**Mood & Nerves**	□ Acne on chest
□ Eye pain	□Agoraphobia	□ Acne on face
□ Headache	□ Anxiety	□ Acne on shoulders
□ Hearing loss	□ Auditory hallucinations	□ Athlete's foot
□ Hearing problems	□ Black-out	□ Cellulitis
□ Lid margin redness	□ Depression	□ Dark circles under eyes
□ Migraine	□ Difficulty: □ Concentrating	□ Bumps on back of upper arms
□ Sensitivity to loud noises	□ With balance	□ Ears get red
□ Vision problems (except glasses)	□ With thinking	□ Easy bruising
Musculoskeletal	□ With judgment	□ Eczema
□ Back muscle spasm	□ With speech	□ Herpes - genital
□ Calf cramps	□ With memory	□ Hives
□ Chest tightness	□ Dizziness (spinning)	□ Jock itch
□ Foot cramps	□ Fainting	□ Lacks luster, skin
□ Joint deformity	□ Fearfulness	□ Moles w color/size change
□ Joint pain	□ Irritability	□ Oily skin
□ Joint redness	□ Light-headedness	□ Pale skin
□ Joint stiffness	□ Numbness	□ Patchy dullness
□ Muscle pain	□ Other Phobias	□ Psoriasis
□ Muscle spasms	□ Panic attacks	□ Rash
□ Muscle stiffness	□ Paranoia	□ Red face
□ Muscle twitches: Around eyes	□ Seizures	□ Sensitive to bites
Arms or legs	□ Suicidal thoughts	□ Sensitive to poison ivy/oak

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□ Muscle weakness	□ Tingling	□ Shingles
□ Sensitive to sunlight	□ Throat dryness	□ Hay fever : Spring
□ Skin darkening	□ Mouth dryness	□ Hayfever: Summer
□ Strong body odor	□ Scalp dryness	□ Hayfever: Fall
□ Thick calluses	□ Any dandruff?	□ Hayfever: Change of season
□ Vitiligo	□ Skin dryness in general	□ Hoarseness
Skin itching	**Lymph nodes**	□ Nasal stuffiness
□ Anus	□Enlarged/neck	□ Nose bleeds
□ Arms	□ Tender/neck	□ Post nasal drip
□ Ear canals	□ Other enlarged/tender lymph nodes	□ Sinus fullness
□ Eyes	**Nails**	□ Sinus infection
□ Feet	□ Bitten	□ Snoring
□ Hands	□ Brittle	□ Sore throat
□Legs	□ Curve up	□ Wheezing
□ Nipples	□ Frayed	□ Winter stuffiness
□ Nose	□ Fungus - fingers	**Heart**
□ Penis	□ Fungus - toes	□ Angina/chest pain
□ Roof of mouth	□ Pitting	□ Breathlessness
□ Scalp	□ Ragged cuticles	□ Heart attack
□ Skin in general	□ Ridges	□ Heart murmur
□ Throat	□ Soft	□ High blood pressure
Skin Dryness	□ Thickening of fingernails	□ Irregular pulse
□ Eyes	□ Thickening of Toenails	□ Mitral valve prolapse
□ Feet	□ White spots/lines	□ Palpitations
□ Any cracking?	**Respiratory**	□ Phlebitis
□ Any peeling?	□ Bad breath	□ Swollen ankles/feet
□ Hair	□ Bad odor in nose	□ Varicose veins

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Hands □ Any peeling	□ Cough - dry	**Urine**
Hands □ Any cracking?	□ Cough - productive	□ Bed wetting
□ Urine urgency	□ Excessive fatigue post intercourse	□ urinary Hesitancy
□ Urine Infection	**Female Reproductive**	□ Constipation
□ Kidney disease	□ Breast cysts	□ Decreased sleep
□ Kidney stone	□ Breast lumps	□ Diarrhea
□ Leaking/incontinence of urine	□ Breast tenderness	□ Fatigue
□ Pain/burning with urination	□ Ovarian cyst	□ Increased sleep
□ Prostate enlargement	□ Poor sex desire	□ Irritability
□ Prostate infection	□ Endometriosis	Menstrual: □ Cramps
□ Urine Urgency	□ Fibroids	□ Heavy periods
Male Reproductive	□ Vaginal discharge	□ Irregular periods
□ Discharge from penis	□ Vaginal odor	□ No periods
□ Ejaculation problem	□ Vaginal itch	□ Scanty periods
□ Genital pain	□ Vaginal pain	□ Spotting between
□ Impotence	Premenstrual: □ Bloating	Other symptoms
□ Infection	□ Breast tenderness	□ Hair loss
□ Lumps in testicles	□ Carbohydrate craving	□ Tremor or trembling
□ Poor sex desire	□ Chocolate craving	_____.

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Medications and Supplements

List all medications including over the counter medications, vitamins, mineral and supplements that you are using.

Name	Dose	How frequently do you take them?	Start Date	Reason for use
List medications or supplements that you used in the past 5-10 years				

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Adverse Reactions

Have medications or supplements caused any adverse reactions?

Medication/ Supplement/ food/ environment such as paints	adverse reaction

Do you have any history of long term or frequent use of

□ Antibiotics □ Steroids □ Birth control pills □ Tylenol

□ Over the counter pain meds like Motrin and Advil

Social History

Smoking □ Never smoked

□ Current smoker How long? ____years Packs per day ___ Quit Attempts ___

□ Ex-smoker How long? ____years Packs per day ___

Alcohol Intake □ No alcohol use

Previous alcohol intake □ Mild □ Moderate □ High

Drinks per week □ 1-3 □ 4-6 □ 7-10 □ > 10

Have you ever felt guilty about your drinking? □ Yes □ No

Have people annoyed you by criticizing your drinking? □ Yes □ No

Have you used a drink first thing in the morning to steady nerves? □ Yes □ No

Has anyone around you expressed concern about your drinking? □ Yes □ No

Current use of recreational Drugs □ Yes, Specify _____ □ No

Past Use of recreational Drugs □ Yes, Specify _____ □ No

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Family History

Check all that applies	Mother	Father	Sister	Brother	Grand parents	Other
Age						
Age at death (if deceased)						
High blood pressure						
Diabetes						
Obesity						
Heart Disease						
Stroke						
Autoimmune disease e.g. lupus						
Inflammatory Bowel Disease						
Irritable Bowel Syndrome						
Celiac Disease						
Psoriasis/Eczema						
Breast cancer						
Colon cancer						
Other cancers						
Dementia						
Parkinson’s Disease						
Substance abuse such as alcoholism						
Depression/Bipolar						
Other _____						

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Nutrition History

Height _____ feet _____ inches Weight _____ lbs Desired weight _____

Waist size _____ cm Hip size _____ cm

How frequently do you weigh yourself? □ Daily □ weekly □ monthly □ Rarely

Have you made any changes to your diet for health reasons? □ Yes □ No
If yes, please specify_____

What type of diets are you currently following?
□ Regular □ Low fat □ Low carbohydrate □ High Protein □ low sodium
□ Diabetic □ No Gluten □ No dairy □ Vegetarian □ Vegan
□ Paleo Other _____

Do you cook? □ Yes □ No Do you grocery shop? □ Yes □ No

The most heavy meal of your day? □ Breakfast □ Lunch □ Dinner

Regular meals a day □ Breakfast □ Lunch □ Dinner

Number of times you eat out every week □ 0-1 □ 2-3 □ 4-5 □> 5

Which of the following applies to you?

□ Love to eat □ Fast eating □ Erratic eating pattern

□ Inadequate chewing □ Eating too much □ Forcing myself to eat

□ Inadequate time to eat □ Frequent traveling □ No time to cook

□ Mostly eating outside □ Dependence on convenient options

□ Poor snack choices □ Late night eating □ Not interested in cooking

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□ Emotional eating (eat when lonely, depressed or bored)
□ Eating in the middle of night □ Eat too much under stress

□ Struggle with eating healthy foods □ Eat too little under stress

□ Confused about nutrition (not sure what to eat)

□ Significant other has special dietary needs or does not like healthy foods

Stool frequency
□ 1-2 times a day □ 3-4 times a day □ 5 or more times a day □ 4-6 times a week
□ 2-3 times a week □ 1 or less times a week

Stool consistency
□ Soft and well formed □ Often float □ Difficult to pass □ Diarrhea
□ Small and hard □ Loose but not water
□ Alternate between hard and loose/watery stool

Check all that applies to you		
□ Sour or acidic stomach	□ Heavy feeling after eating on a regular basis	□ Gas and bloating
□ Ravenous hunger	□ Sleepy after eating	□ Belching
□ Can eat anything	□ Can easily skip a meal	□ Variable hunger
□ Heartburn or reflux	□ regular, well formed daily bowel movement	□ Constipation tendency
□ Tendency for loose stool	Food just sits there in stomach	□ Erratic or variable digestion (sometimes regular and other times irregular bowel movements

The most important thing I would like to change about my diet is

_____

Sleep History

Sleep is important for musculoskeletal healing and for healthy immune function, mood, cognitive and brain function, and for many physiological functions.

1. Average number of hours of sleep per night _____
2. Do you have sleep problems? □ Yes □ No
3. Do you feel well rested in the morning? □ Yes □ No
4. Do you take more than 3 minutes to fall asleep? □ Yes □ No
5. Do you have trouble staying asleep? □ Yes □ No
6. Are there times during the day or evening when you feel sleepy? □ Yes □ No

   If yes what do you do to keep yourself awake_____

7. Have you ever had an accident because you were sleepy? □ Yes □ No
8. Do you take naps during the day? □ Yes □ No

   If yes, number of naps _____ Duration of naps _____ minutes

9. Do you feel so wired at night that it is difficult for you to fall asleep? □ Yes □ No
10. Do you wake up in the middle of the night? □ Yes □ No

    If yes, number of times you wake up _____

,

    Reason for waking up _____

    Do you have trouble falling back to sleep? □ Yes □ No

    How long does it take for you to go back to sleep? _____minutes

11. Do you use sleep Aids in the form of medications or supplements? □ Yes □ No
    If yes, specify _____

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Exercise History

Activity	Type	Frequency per week	Duration in minutes
Stretching			
Cardio/Aerobics			
Strength training			
Other (yoga, pilates etc.)			
Sports or Leisure			

2. How motivated are you to include exercise in your life? □ Low □ Medium □ High

3. Is there anything that limits your ability to exercise?

□ Yes □ No If yes, explain:

_____

4. Do you have any joint or musculoskeletal problems that might flare up during exercise?

□ Yes □ No If yes, explain:

_____

5. Have you had any injuries while exercising?

□ Yes □No If yes, please describe:

_____

6. What is your exercise goal and are you meeting it?

_____

7. Are you able to schedule and follow through with your exercise?

□ Yes □ No If not, what is the reason?

_____

8. When do you have the most energy and time?

_____

9. Have you lost any muscle over the last few years?	□ Yes	□ No
10. Have you fallen in the past few months?	□ Yes	□ No
11. Do you feel like you are steady on your feet?	□ Yes	□ No
13. Do you feel like you have any balance problems?	□ Yes	□ No

Depression, Anxiety & Stress Score

0=Does not apply to me, 1=applies some of the ime, 2=applies to a good part of time
3=applies most of the time Time Frame: Past 2 weeks

#	Symptoms	0	1	2	3
1	I found myself getting upset by quite trivial things				
2	I was aware of dryness of my mouth				
3	I could not seem to experience any positive feelings at all				
4	I experienced breathing difficulty (in the absence of exertion)				
5	I just couldn't seem to get going				
6	I trended to over-react to situations				
7	I had a feeling of shakiness (e.g. legs going to give away)				
8	I found it difficult to relax				
9	I found myself in situations that made me so anxious I was most relieved when they ended				
10	I felt I had nothing to look forward to				
11	I found myself getting upset rather easily				
12	I felt that I was using a lot of nervous energy				
13	I felt sad and depressed				
14	I found myself getting impatient when I was delayed in any way (e.g. traffic)				
15	I had a feeling of faintness				
16	I felt I had lost interest in just about everything				
17	I felt I wasn't worth much of a person				
18	I felt that I was rather touchy				
19	I perspired noticeably e.g. sweaty hands in the absence of high temperature or physical exertion				

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20	I felt scared without any good reason				
21	I felt that life wasn't worthwhile				
22	I found it hard to wind down				
23	I had difficulty in swallowing				
24	I couldn't seem to get any enjoyment out of things I did				
25	I was aware of my heart rate or palpitations or missing a beat in the absence of exertion				
26	I felt downhearted and blue				
27	I found that I was irritable				
28	I felt I was close to panic				
29	I found it hard to calm down after something upset me				
30	I feared that I would be thrown by some trivial but unfamiliar task				
31	I was unable to become enthusiastic about anything				
32	I found it difficult to tolerate interruption to what I was doing				
33	I was in a state of nervous tension				
34	I felt I was pretty worthless				
35	I was intolerant of anything that kept me from getting on with what I was doing				
36	I felt terrified				
37	I could see nothing in the future to be hopeful about				
38	I felt that life was meaningless				
39	I found myself feeling agitated				
40	I was worried about situations in which I might panic and make a fool of myself				
41	I experienced trembling				
42	I found it difficult to work up the initiative to do things				

Stress

Would you consider your childhood to be happy and secure? □ Yes □ No

Have you experienced any major loss or emotional trauma? □ Yes □ No

Do you think you are happy? □ Yes □ No

Are you happy with your job? □ Yes □ No

Do you feel you have an excessive amount of stress in your life?

Rate your ability to cope with stress □Mild □Moderate □ High

Rate the following stressors on a scale of 1-10 with 10 being the highest

____ Spouse/significant other	____ Financial	____ Children
____ Parents	____ Mental health	____ Physical Health
____School	____ Close friends	____ Job
____Others_____		

Do you practice any Mind Body Relaxation technique? □ Yes □ No

If yes specify □ Yoga □ Tai Chi □ Breathing □ Meditation

□ Prayer □ Mindfulness □Other _____

Rate your relationship with your parents on a scale of 1-10 with 10 being ideal

Mother ____ Father ____

Social Support

Are you □ single □ Married □ Divorced □ Widowed □ Long term relationship

Number of children_____ Ages _____ Gender _____

Source of social support

□ Spouse/significant other	□ Children	□ Friends	□ Pets
□ Community	□ Religion/Spiritual	□ Other _____	

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Readiness Assessment

Rate your motivation on a scale of 1-5 with 1 being not motivate and 5 being very motivated in making the following changes to improve your health

Significantly modifying your diet	5 □	4 □	3 □	2□	□ 1
Engaging in regular exercise	5 □	4 □	3 □	2□	□ 1
Modifying your lifestyle	5 □	4 □	3 □	2□	□ 1
Getting periodic lab tests to monitor your progress	5 □	4 □	3 □	2□	□ 1
Taking supplements on a daily basis	5 □	4 □	3 □	2□	□ 1
Tracking your diet and symptoms on a daily basis	5 □	4 □	3 □	2□	□ 1
Practice a mind body relaxation technique	5 □	4 □	3 □	2□	□ 1

Rate your confidence in making the above changes on a scale from 1 (not confident) to 5 (Very confident) 5 □ 4 □ 3 □ 2□ □ 1

List the top 3 barriers do you think you will face when trying to make these changes

1._____

2. _____

3. _____

How frequent follow-up visits will help you in helping you implement your personal health plan?

Every 2 months □ Monthly □ Every 3 weeks □ Every 2 weeks □ Every week□

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