

Information for New Clients

Please read carefully. It explains what to expect and what you need to send.

WHAT TO EXPECT-- During your first phone interview we will review your forms, medical information, personal history and special goals. You will be sent a food and supplement plan and a workbook that will explain the overriding theories presented in your program. ***You are expected to follow up with phone, fax or email reports on your progress and to participate fully in evaluating the appropriateness of your plan.*** I am a nutrition educator. You are making an investment in your future. Ask questions. If you do, you will find long term answers. The information we gather together about your body will enable you to take the best possible care of yourself for the rest of your life.

WHAT TO SEND -- your forms; a four day food diary; a list of your questions; medical information including blood tests if available; a complete **list of supplements** with dose information, those you use *and those you do not use*; a complete **list of medications** with dose information; any other information you think may be important.

WHAT ABOUT CHARGES? -- Phone/Mail/E-mail Consultations and Program Support Appointments are billed at a rate of \$90 per hour, no minimum time. All consultation and program support billing will include charges for the time it takes to research and write your program in addition to online or phone time. No home visits at the current time. **Clients will be invoiced following the consult. Invoices are due when received. Please keep your account current.** Phone follow-up time is recorded and an invoice/statement sent periodically, due on receipt.

WHAT ABOUT TOTAL COSTS? -- Your initial assessment will take about two or three hours depending on the complexity of your situation and the questions you ask. This time includes research, interview, prep and send. You will be charged for 'actual time' used to gather, prepare and send you your program information. Program support is provided as needed at the same rate, \$90 per hour, billed by the minute.

Chronic conditions or serious illness may need more extended support time and will increase the total cost. Suggested supplements or special foods will add to your costs. Supplements average \$25-\$75 a month, at times more when specific medical conditions are being addressed..

I DON'T SELL VITAMIN AND MINERAL SUPPLEMENTS. I believe suggesting and then selling specific supplements would be a conflict of interest for my clients. It also would not help clients learn to access what they need 'where ever they are'.

TESTING—Testing vitamin D is critical as many persons are lacking sufficient amounts of this pre-hormone. Other than the vitamin D test I use minimal testing as needed determined by your initial interview and questionnaire. Fees are paid to the labs. Tests worth the cost if deemed necessary may include:

A **standard blood panel** with a **Chemistry 25/27, CBC, Platelet Count and Differential-** This test is similar to your yearly blood test. Cost: Varies with lab, paid by your insurance or by you to the lab.

Great Smokie's Comprehensive Digestive Stool Analysis with Parasitology or DiagnosTech's GI panel- Stool and salivary samples give information on the condition of digestion and the intestinal tract that can not be determined by other testing methods. This test is suggested for clients with chronic digestive disturbances. The cost is approximately \$180-\$260.

Salivary Hormone Testing- Various panels such as Male; Female; Postmenopausal; Adrenal Stress Index; DHEA; IGF-1 (growth hormone) and Melatonin. Depending on panel/s \$45-\$250.

SpectraCell's Essential Metabolic Analysis- shows cellular levels of 19 key elements. It is utilized for serious, critical conditions only, when we have been unable to determine the underlying condition by any other method. The cost is about \$350.

On a separate sheet write all the "Questions I would like to ask about nutrition":

Krispin Sullivan, CN
202 Marylyn Circle
Petaluma, CA 94954

krispin@krispin.com
<http://krispin.com>
1-707-769-1301

DATE: / /

CLIENT PROFILE

PLEASE FILL OUT COMPLETELY, BOTH SIDES AND
SIGN STATEMENT AT BOTTOM OF OTHER SIDE

NAME		MARITAL STATUS (CIRCLE ONE) S / M / D / W	
ADDRESS			
CITY		STATE	ZIP
HOME PHONE:		EMAIL	
FAX / CELL PHONE (circle one):		BIRTHDATE:	AGE:
OCCUPATION:		CHILDREN #	AGES:

CHILDHOOD DISEASES/INJURIES/SURGURIES:

Were you abused or neglected?

CHILDHOOD MEDICATIONS:

ADULT DISEASES / ACCIDENTS / SURGERIES: (Women include detailed reproductive history including any pregnancy, miscarriage, abortion or menstrual cycle issues. Men include any sexual, urinary and prostate

ALLERGIES (include age of first occurrence):

ADULT MEDICATIONS PAST with doses and dates (all current medications should be listed on the sheet provided):

CURRENT HEIGHT AND WEIGHT:

HGT:

WGT:

IDEAL WEIGHT:

WEIGHT HISTORY (if applicable) If long and detailed continue explanation under Major Concerns:

FAVORITE FOODS / CRAVINGS (to give me an idea of foods you like and re cravings to show what your body seeks out. Put all cravings, even for 'bad' things):

CURRENT MAJOR CONCERNS- These are your goals, the things you want to change. Use extra sheets if needed:

SUBSTANCE ABUSE-FOOD / DRUG / ALCOHOL HISTORY (if applicable):

FAMILIAL MEDICAL DISEASES (blood relatives only, parents, grandparents, aunts, uncles, and the like):

I understand that I am the primary person responsible for my health care. In all cases I must make the final decision about what is right for me. It is possible that Ms. Sullivan may deem it necessary for me to see a physician, my own or a referral, because of conditions I may report. I agree to follow-up with that advice. I understand that Krispin Sullivan is not a physician and does not diagnose disease nor does she treat disease with diet and supplements. Any program she may suggest for me is not in lieu of competent medical care. Nutrition supports health. It may also enhance the positive effects and/or help reduce the negative side-effects of medically necessary treatment as prescribed by a physician. I understand that my refusal to seek medical care, if and when deemed necessary, would make it impossible for Ms Sullivan to work with me.

SIGNATURE

DATE

NAME: _____ DATE: _____

SUPPLEMENT AND MEDICATION LIST

Make sure to include a copy of the label of any multiple supplements. Include the dose per tablet and number of tablets taken at each time. Example- B-6 50 mg 1 tablet or thyroid 0.125 1 tablet or Inhaler 1 spray or My Favorite Multiple 2 tablets with breakfast and 2 tablets with dinner (include label on this). If medications are taken occasionally put them at the bottom or on the back. If you often miss a daily dose of medications or supplements please note that.

On arising:

With first meal:

With lunch:

With dinner:

Before bed:

Any other times and doses:

Health Appraisal Questionnaire

Name: _____

Date: _____

Part I

Circle any of the following medications you are taking:

- | | | | | | | |
|-----------------------------|--------------------------|---------------------------------|----------------------------------|--------------------|-----------------------|------------------------------|
| • Antacids | • Antidiabetic / Insulin | • Cortisone / Anti-inflammatory | • High Blood Pressure Medication | • Laxatives | • Radiation | • Relaxants / Sleeping Pills |
| • Antibiotics / Antifungals | • Aspirin / Tylenol | • Heart Medications | • Hormones | • Lithium | • Chemotherapy | • Thyroid Medication |
| • Antidepressants | • Recreational Drugs | | | • Ulcer Medication | • Oral Contraceptives | |
- Specify Type _____
- Other _____

Circle if you eat, drink or use:

- | | | | | |
|------------------------|-------------------|--|------------------------------|--|
| • Alcohol | • Coffee | • Luncheon meats | • Refined sugars | • Vitamins and / or minerals (Please List) |
| • Candy | • Distilled water | • Margarine | • Saccharine (Sweet and Low) | _____ |
| • Carbonated beverages | • Fried foods | • Eat at fast food restaurants regularly | | _____ |
| • Cigarettes | • Chew tobacco | | | _____ |

Circle if you:

- | | | |
|-----------------------------|------------------------------|------------------------------------|
| • Diet often | • Salt food without tasting | • Are exposed to chemicals at work |
| • Do not exercise regularly | • Are under excessive stress | • Are exposed to cigarette smoke |

INSTRUCTIONS: Circle the number which best describes the intensity of your symptoms. If you do not know the answer to a question, leave it blank.

0 = Symptom is not present 1 = Mild 2 = Moderate 3 = Severe

Part II

SECTION C:

SECTION A:

- | | | | | |
|---|---|---|---|---|
| 1. Burping | 0 | 1 | 2 | 3 |
| 2. Fullness for extended time after meals | 0 | 1 | 2 | 3 |
| 3. Bloating | 0 | 1 | 2 | 3 |
| 4. Poor appetite | 0 | 1 | 2 | 3 |
| 5. Stomach upsets easily | 0 | 1 | 2 | 3 |
| 6. History of constipation | 0 | 1 | 2 | 3 |
| 7. Known food allergies | 0 | 1 | 2 | 3 |

SECTION B:

- | | | | | |
|---|---|---|---|---|
| 1. Abdominal cramps | 0 | 1 | 2 | 3 |
| 2. Indigestion 1-3 hours after eating | 0 | 1 | 2 | 3 |
| 3. Fatigue after eating | 0 | 1 | 2 | 3 |
| 4. Lower bowel gas (flatulence) | 0 | 1 | 2 | 3 |
| 5. Alternating constipation and diarrhea | 0 | 1 | 2 | 3 |
| 6. Diarrhea | 0 | 1 | 2 | 3 |
| 7. Roughage and fiber causes constipation | 0 | 1 | 2 | 3 |
| 8. Mucous in stools | 0 | 1 | 2 | 3 |
| 9. Stool poorly formed | 0 | 1 | 2 | 3 |
| 10. Shiny stool | 0 | 1 | 2 | 3 |
| 11. Three or more large bowel movements daily | 0 | 1 | 2 | 3 |
| 12. Foul smelling stool | 0 | 1 | 2 | 3 |
| 13. Dry, flaky skin and / or dry brittle hair | 0 | 1 | 2 | 3 |
| 14. Pain in left side under rib cage | 0 | 1 | 2 | 3 |
| 15. Acne | 0 | 1 | 2 | 3 |
| 16. Food allergies | 0 | 1 | 2 | 3 |
| 17. Difficulty gaining weight | 0 | 1 | 2 | 3 |

- | | | | | |
|---|----|---|---|---------------------|
| 1. Stomach pains | 0 | 1 | 2 | 3 |
| 2. Stomach pains just before and / or after meals | 0 | 1 | 2 | 3 |
| 3. Dependency on antacids | 0 | 1 | 2 | 3 |
| 4. Chronic abdominal pain | 0 | 1 | 2 | 3 |
| 5. Butterfly sensations in stomach | 0 | 1 | 2 | 3 |
| 6. Difficulty belching | 0 | 1 | 2 | 3 |
| 7. Stomach pain when emotionally upset | 0 | 1 | 2 | 3 |
| 8. Sudden, acute indigestion | NO | | | YES |
| 9. Relief of symptoms by carbonated beverages | NO | | | YES |
| 10. Relief of stomach pain by drinking cream / milk | NO | | | YES |
| 11. History of ulcer or gastritis | NO | | | YES |
| 12. Current ulcer | NO | | | YES ⁽¹⁰⁾ |
| 13. Black stool when not taking iron supplements | NO | | | YES ⁽¹⁰⁾ |

SECTION D:

- | | | | | |
|--|----|---|---|-----|
| 1. Seasonal diarrhea | 0 | 1 | 2 | 3 |
| 2. Frequent and recurrent infections (colds) | 0 | 1 | 2 | 3 |
| 3. Bladder and kidney infections | 0 | 1 | 2 | 3 |
| 4. Vaginal yeast infection | 0 | 1 | 2 | 3 |
| 5. Abdominal cramps | 0 | 1 | 2 | 3 |
| 6. Toe and fingernail fungus | 0 | 1 | 2 | 3 |
| 7. Alternating diarrhea / constipation | 0 | 1 | 2 | 3 |
| 8. Constipation | 0 | 1 | 2 | 3 |
| 9. History of antibiotic use | NO | | | YES |
| 10. Meat eater | NO | | | YES |
| 11. Rapidly failing vision | NO | | | YES |

Part III

SECTION A:

- | | | | | |
|---|---|---|---|---|
| 1. Intolerance to greasy foods | 0 | 1 | 2 | 3 |
| 2. Headaches after eating | 0 | 1 | 2 | 3 |
| 3. Light coloured stool | 0 | 1 | 2 | 3 |
| 4. Foul smelling stool | 0 | 1 | 2 | 3 |
| 5. Less than one bowel movement daily | 0 | 1 | 2 | 3 |
| 6. Constipation | 0 | 1 | 2 | 3 |
| 7. Hard stool | 0 | 1 | 2 | 3 |
| 8. Sour taste in mouth | 0 | 1 | 2 | 3 |
| 9. Grey coloured skin | 0 | 1 | 2 | 3 |

- | | | | | |
|---|----|---|---|--------------------|
| 10. Yellow in whites of eyes | 0 | 1 | 2 | 3 |
| 11. Bad breath | 0 | 1 | 2 | 3 |
| 12. Body odor | 0 | 1 | 2 | 3 |
| 13. Fatigue and sleepiness after eating | 0 | 1 | 2 | 3 |
| 14. Pain in right side under rib cage | 0 | 1 | 2 | 3 |
| 15. Painful to pass stool | 0 | 1 | 2 | 3 |
| 16. Retain water | 0 | 1 | 2 | 3 |
| 17. Big toe painful | 0 | 1 | 2 | 3 |
| 18. Pain radiates along outside of leg | 0 | 1 | 2 | 3 |
| 19. Dry skin / hair | 0 | 1 | 2 | 3 |
| 20. Red blood in stool | NO | | | YES ⁽⁶⁾ |

Part III Section A (Continued)

21. Have had jaundice or hepatitis	NO	UNKNOWN	YES	8. Chronic fatigue	0	1	2	3
22. High blood cholesterol and low HDL cholesterol ...	NO	UNKNOWN	YES ⁽¹⁰⁾	9. Trouble waking up in the morning	0	1	2	3
23. Is your cholesterol level above 200?.....	NO	UNKNOWN	YES	10. Depressed, apathetic	0	1	2	3
24. Is your triglyceride level above 115 ?.....	NO	UNKNOWN	YES	11. Low sex drive	0	1	2	3

SECTION B:

1. Swollen eyes (bulging)	0	1	2	3	12. Puffy, wrinkly skin	0	1	2	3
2. Strong smelling urine	0	1	2	3	13. Sugar causes irritability and mood swings	0	1	2	3
3. Thick skin and finger nails	0	1	2	3	14. Premenstrual tension	0	1	2	3
4. Dry skin	0	1	2	3	15. Constipation	0	1	2	3
5. Sensitive to the cold	0	1	2	3	16. Thinning or loss of outside portion of eyebrow	0	1	2	3
6. Cold hands and feet	0	1	2	3	17. Gain weight easily	0	1	2	3
7. Excessive menstrual bleeding	0	1	2	3	18. Anemia unaffected by iron	NO			YES
					19. Axillary (armpit) temperature below 36.4°C (97.6°F) ..	NO			YES
					20. Slow reflexes	NO			YES
					21. Infertility	NO			YES

Part IV

SECTION A:

1. Sensitive to exhaust fumes, smoke, smog and / or petrochemicals	0	1	2	3
2. Periodic constipation	0	1	2	3
3. Cannot tolerate much exercise	0	1	2	3
4. Depression or rapid mood swings	0	1	2	3
5. Dark circles under the eyes	0	1	2	3
6. Dizziness upon standing	0	1	2	3
7. Lack of mental alertness	0	1	2	3
8. Catch colds easily when weather changes	0	1	2	3
9. Headaches	0	1	2	3
10. Difficulty breathing	0	1	2	3
11. Water retention	0	1	2	3
12. Eyes sensitive to bright light	0	1	2	3
13. Feel weak and shaky	0	1	2	3

SECTION B:

1. Inflamed or bleeding gums	0	1	2	3
2. Running nose	0	1	2	3
3. Get boils or styes	0	1	2	3
4. Nose bleeds	0	1	2	3
5. Loss of smell	0	1	2	3
6. Throat infections	0	1	2	3
7. Cold sores, fever blisters	0	1	2	3
8. Loss of taste	0	1	2	3
9. Poor wound healing	0	1	2	3
10. Hair falls out	0	1	2	3
11. Swollen lymph glands	0	1	2	3
12. Ear infections	0	1	2	3
13. Hair grows slowly	0	1	2	3
14. Slow to recover from cold or flu	0	1	2	3
15. Catch colds or flu easily	0	1	2	3
16. Bumpy skin on back of arms	0	1	2	3

SECTION C:

1. Itching of nose or eyes	0	1	2	3
2. Itching of roof of mouth or throat	0	1	2	3
3. Migraine headaches	0	1	2	3
4. Entire body aches, painful to touch	0	1	2	3
5. Swollen joints	0	1	2	3
6. Food sensitivity or allergy	0	1	2	3
7. Certain foods make you sick, depressed, jittery	0	1	2	3
8. Chronic pain	0	1	2	3
9. Painful stomach and / or intestine	0	1	2	3
10. Alternating constipation and diarrhea	0	1	2	3
11. Mucous in throat	0	1	2	3
12. Post nasal drip	0	1	2	3
13. Discharge from eyes	0	1	2	3
14. Watery eyes	0	1	2	3
15. Puffiness or dark circles under eyes	0	1	2	3
16. Ear discharge or ears stuffed up	0	1	2	3
17. Nasal congestion	0	1	2	3
18. Running nose	0	1	2	3
19. Breathe through mouth	0	1	2	3
20. Swollen tongue	0	1	2	3
21. Difficulty swallowing	0	1	2	3
22. Bedwetting	0	1	2	3
23. Hyperactivity	0	1	2	3
24. Chronic lung congestion	0	1	2	3
25. Use aspirin or Tylenol regularly	0	1	2	3
26. Wheezing	0	1	2	3
27. Skin rashes	0	1	2	3
28. Sneezing	0	1	2	3

Part V

SECTION A:

1. Difficulty breathing at night	0	1	2	3
2. Chest pain while waking	0	1	2	3
3. Heaviness in legs	0	1	2	3
4. Calf muscles cramp while walking	0	1	2	3
5. Heart pounds easily	0	1	2	3
6. Feel jittery	0	1	2	3
7. Heart misses beats or has extra beats	0	1	2	3
8. Swelling of feet and ankles	0	1	2	3
9. Rapid beating heart	0	1	2	3
10. Heartburn after eating	0	1	2	3
11. Pain in left arm	0	1	2	3
12. Exhaust with minor exertion	0	1	2	3
13. Do you do aerobic exercise?	YES			NO
14. Have you ever exercised regularly?	YES			NO
15. Drink 5 or more cups of coffee daily	NO			YES
16. Severe cough	NO			YES
17. Has a doctor ever told you that you have heart trouble?	NO			YES ⁽⁶⁾

SECTION B:

1. Cold hands and feet	0	1	2	3
2. Slurred speech	0	1	2	3
3. Calf muscles cramps while walking	0	1	2	3
4. Headaches	0	1	2	3
5. Numbness	0	1	2	3
6. Poor concentration	0	1	2	3
7. Ringing in ears	0	1	2	3
8. Ear canal hair	NO			YES
9. Tingling and / or burning in hands or feet	NO			YES
10. Spider veins on nose and / or face	NO			YES

SECTION C:

1. Pain when getting up in morning in back of head and neck	0	1	2	3
2. Dizziness	0	1	2	3
3. Vertigo	0	1	2	3
4. Blushing with no apparent cause	0	1	2	3
5. Is your blood pressure high?	NO			YES ⁽¹⁰⁾

Part VI

SECTION A:

1. Dizziness when standing suddenly	0	1	2	3
2. Loss of vision when standing suddenly	0	1	2	3
3. Crave sweets	0	1	2	3
4. Headaches relieved by eating sweets or alcohol ..	0	1	2	3
5. Feel shaky or jittery	0	1	2	3
6. Irritable if a meal is missed	0	1	2	3
7. Wake up in middle of night craving sweets	0	1	2	3
8. Feel tired or weak if a meal is missed	0	1	2	3
9. Heart palpitations after eating sweets	0	1	2	3
10. Need to drink coffee to get started	0	1	2	3
11. Impatient, moody, nervous	0	1	2	3
12. Feel tired 1 to 3 hours after eating	0	1	2	3
13. Poor memory	0	1	2	3
14. Feel faint	0	1	2	3
15. Poor concentration	0	1	2	3
16. Forgetful	0	1	2	3
17. Calmer after eating	NO			YES

SECTION B:

1. Night sweats	0	1	2	3
2. Increased thirst	0	1	2	3
3. Lowered resistance to infection	0	1	2	3
4. Fatigue	0	1	2	3
5. Boils and leg sores	0	1	2	3
6. Lesions, cuts take a long time to heal	0	1	2	3
7. Overweight	0	1	2	3
8. Feel pick up from exercise	0	1	2	3
9. Failing eyesight	0	1	2	3
10. Crave sweets, but eating sweets does not relieve symptoms	0	1	2	3
11. Family history of diabetes	NO			YES
12. Sugar in urine	NO			YES

Part VII

1. Chest pain	0	1	2	3
2. Chronic cough	0	1	2	3
3. Difficulty breathing	0	1	2	3
4. Coughing up blood	0	1	2	3
5. Coughing up phlegm	0	1	2	3
6. Pain around ribs	0	1	2	3
7. Shortness of breath	0	1	2	3

8. Rattling mucous when you breathe	0	1	2	3
9. Sensitive to smog	0	1	2	3
10. Infections settle in lungs	0	1	2	3
11. Live or work around people who smoke	0	1	2	3
12. Bronchitis	NO			YES ⁽¹⁰⁾
13. Exposed to chemicals and / or radiation	NO			YES ⁽⁶⁾
14. Smoker	NO			YES ⁽⁶⁾

Part VIII

1. Frequent urination	0	1	2	3
2. Frequent bladder infections	0	1	2	3
3. Rarely need to urinate	0	1	2	3
4. Urination when you cough or sneeze	0	1	2	3
5. Painful / burning when passing urine	0	1	2	3
6. Difficulty passing urine	0	1	2	3
7. Dripping after urination	0	1	2	3
8. Can't hold urine	0	1	2	3
9. Rose coloured (bloody) urine	0	1	2	3

10. Cloudy urine	0	1	2	3
11. Strong smelling urine	0	1	2	3
12. Back or leg pains associated with dripping after urination	0	1	2	3
13. History of kidney or bladder infections	NO			YES
14. Have used antibiotics to control urinary tract infections	NO			YES
IF YES, when did you last use them? _____ TREATMENT DURATION _____				
15. Back pain in the kidney area	0	1	2	3
16. General water retention	0	1	2	3

MALES ONLY

Part IX

SECTION A:

1. Difficulty urinating	0	1	2	3
2. A sense of bladder fullness	0	1	2	3
3. Increased straining with smaller and smaller amounts of urine passed	0	1	2	3
4. Rose coloured (bloody) urine	0	1	2	3
5. Pain or burning while urinating	0	1	2	3
6. Wake up to urinate at night	0	1	2	3
7. Dripping after urination	0	1	2	3
8. Pain or fatigue in the legs or back	0	1	2	3
9. Lack of sex drive	0	1	2	3
10. Ejaculation causes pain	0	1	2	3

2. Low sexual drive	0	1	2	3
3. Premature ejaculation	0	1	2	3
4. Pain / coldness in genital area	0	1	2	3
5. Infertile	NO			YES ⁽⁵⁾
6. Varicose veins on scrotum	NO			YES
7. Low sperm count	NO			YES ⁽⁵⁾

SECTION C:

1. Discharge from penis	0	1	2	3
2. Past or present rash on penis	0	1	2	3
3. Swollen genitals	0	1	2	3
4. Swelling in groin	0	1	2	3
5. Venereal disease (gonorrhea, syphilis, herpes, other)	NO			YES ⁽⁹⁾

SECTION B:

1. Difficulty attaining and / or maintaining an erection	0	1	2	3
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Have V.D. now? _____ Had in past? _____

FEMALES ONLY

Part X

SECTION A: Circle if you experience any of these symptoms within approximately 2 weeks (ovulation) prior to menstruation. (Section A ONLY)

1. Monthly weight gain	0	1	2	3
2. Depression	0	1	2	3
3. Moodiness / irritability	0	1	2	3
4. Bloating and swelling	0	1	2	3
5. Nausea and / or vomiting	0	1	2	3
6. Suicidal feeling	NO			YES ⁽¹⁰⁾
7. Anxiety	0	1	2	3
8. Leg cramps and tenderness	0	1	2	3
9. Asthma attacks	NO			YES ⁽¹⁰⁾
10. Headaches	0	1	2	3

11. Easily distracted	0	1	2	3
12. Angry	0	1	2	3
13. Tender breasts	0	1	2	3
14. Low backache	0	1	2	3
15. Other _____				

SECTION B:

1. Vaginal itching	0	1	2	3
2. Vaginal discharge	0	1	2	3
3. Low or no desire for sex	0	1	2	3
4. Dislike for intercourse	0	1	2	3
5. Missed periods	NO			YES
6. Over 15 years of age and have not begun menstruation	NO			YES

Creating a Food Diary

- It is best to record what you eat as soon as you can and record all foods that are eaten.
- Remember to include the beverages you drink as part of what you consume for meals and snacks.
- If you eat a "mixed food" such as a sandwich, include the mayo or butter that you might add to the bread. Include butter that you might put on cooked veggies or dressing that might top off a salad.

Portion Size Guidelines

Here are some portion size guidelines to help you in determining how much you might be eating. Keep in mind, a portion of food is fairly small. The amounts you normally eat probably constitute more than one serving. For example, a typical portion of cooked spaghetti noodles, cereal, or cooked rice equals about 2.5 cups. That's how much we would normally eat! Yet, the correct portion is one half cup. This means that under typical circumstances, we're eating five servings but count it as ONE!

Portions of food: Food Size of one serving easy way to assess

Breads 1 slice store cut slices of loaf bread	Canned fruit 1/2 cup half a fist
Hot dog bun 1/2 of bun whole bun = 2 servings	Fruit juice 3/4 cup size of a medium potato
Hamburger bun 1/2 of bun whole bun = 2 servings	Dried fruits or nuts 1/4 cup sprinkle over the palm
Sub roll 1/2 of a 4" roll whole sub roll = 4+ servings	Milk or yogurt 1 cup size of tennis ball
Cereal 3/4 cup amount to fill a cupcake liner	Cheese 1 1/2-2 ounces size of small bar of soap
Rice, pasta, beans 1/2 cup cooked size of a tangerine	Turkey or chicken 3 ounces size of a small cell phone
Cooked veggies 1/2 cup size of a tangerine	Beef, pork, fish 3 ounces same as above
Raw veggies 1 cup size of a tennis ball	Butter, margarine, oil 1 tablespoon top of your thumb with nail
Fruit 1 small 4" banana or half a fist	

Following is an example of a page from a food diary and a blank form for you to start your own.

Diet Diary for John Hancock Date June 5, 2005

Food Item Eaten/Beverage Consumed Portion Size

Breakfast: 8AM blueberry yogurt—1 serving (6 oz); whole wheat toast—1 piece with butter—1 pat

Snack: 10:30 AM cranberries—1 cup; coffee—1 cup with 2 creams added

Lunch: 1:00 PM turkey sandwich (2 slices wheat bread, 1 tbsp mayonnaise, 1 leaf of lettuce, 1 slice Swiss cheese, about 1 serving of sliced turkey); 1 bag potato chips; 1 medium apple; 1 soda Coke (12-ounce can); and 1 chocolate chip cookie

Snack: 3:30 PM microwave popcorn—1 bag; 1 soda (12-ounce can),

Dinner: 8:00 PM homemade turkey pot pie—2 servings (mixed vegetables—corn, peas, carrots, potatoes; pastry crust; gravy); 1 glass of milk (8 ounces); 1 white dinner roll with butter—1 pat

Snack: 9:30 PM ice cream---3 scoops; 1 soda (12-ounce can),

Water- total daily intake in ounces: 64 ounces

Note: To create a food diary, use the enclosed pages or make multiple copies of the form on the reverse side or make your own equivalent. Please make sure it is readable and that your name and the date are on each page. Please provide a minimum of 3 days. If possible providing 7 days is better.

Record your mood, energy, and cravings for each day and how you slept the night before. Use the back or extra sheets if needed.

Food Diary for _____ Date _____

Time / Food or Beverage / Portion Size

Breakfast:

Snack:

Lunch:

Snack:

Dinner:

Water consumed (just plain water)- daily total in ounces: _____

Cravings:

Energy:

Mood:

Sleep:

Make as many copies as you need for each day or use plain paper but use the same format.

Food Diary for _____ Date _____

Time / Food or Beverage / Portion Size

Breakfast:

Snack:

Lunch:

Snack:

Dinner:

Water consumed (just plain water)- daily total in ounces: _____

Cravings:

Energy:

Mood:

Sleep:

Make as many copies as you need for each day or use plain paper but use the same format.

Food Diary for _____ Date _____

Time / Food or Beverage / Portion Size

Breakfast:

Snack:

Lunch:

Snack:

Dinner:

Water consumed (just plain water)- daily total in ounces: _____

Cravings:

Energy:

Mood:

Sleep:

Make as many copies as you need for each day or use plain paper but use the same format.

Food Diary for _____ Date _____

Time / Food or Beverage / Portion Size

Breakfast:

Snack:

Lunch:

Snack:

Dinner:

Water consumed (just plain water)- daily total in ounces: _____

Cravings:

Energy:

Mood:

Sleep:

Vitamin D Testing

There are two common vitamin D tests currently available.

1. 25(OH)D also called 25-hydroxyvitamin D; or 25-hydroxy
2. 1,25(OH)2D which is 1,25 dihydroxyvitamin D; or 1,25-dihydroxy

25(OH)D is your storage D, the second, 1,25-dihydroxy, your hormone D.

The 25(OH)D test is the right test to order for monitoring vitamin D need and repletion. If your physician orders it for you your insurance may pay. Check, because if your insurance does not pay the test may be quite expensive. It depends on the lab.

As an alternative you may order the 25(OH)D test through the Life Extension Foundation (LEF). For members the cost is approximately \$47, for non-members, \$63. The test results are sent directly to you by LEF.

To order visit <http://lef.org> , Blood Testing, Vitamin D test; or call 800-544-4440.

I do not recommend membership in LEF, nor do I use any of the LEF supplements. I am grateful they provide a way to test D that is easy and relatively inexpensive. You may choose to join or purchase products from them but do not use either of their vitamin D products..

I absolutely do NOT recommend their vitamin D. Both products are dry D and I have found extremely poor utilization of dry D from any source. In addition the 5,000 IU product, if it was absorbed, would be dangerous quite rapidly.

If you have an autoimmune disease or other symptoms or conditions warranting further testing you may need the following blood tests, also ordered by your physician-

25(OH)D

1,25(OH)2D

Plus the following tests that are usually found in a 'panel'

PTH (parathyroid hormone)

Ionized calcium

Total calcium

Full testing including the panel is appropriate for women with bone loss, persons with sarcoidosis, and persons who seem to need D but respond poorly to D supplements and/or sunlight.