YEH CENTER OF NATURAL MEDICINE, INC.
195 North Second Avenue
Upland, California 91786
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PERSONALIZED FOOD CONSULTATION - FORM B

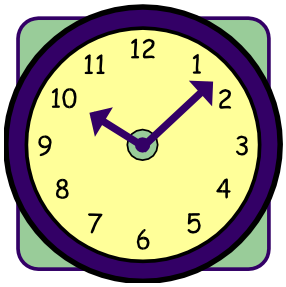
(Please Print)

First Name: _____ Middle Initial: _____ Last Name: _____

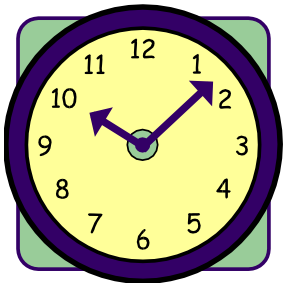
EATING PATTERN:

How would you rate your appetite? o good o fair o poor
How many meals do you eat each day? _____
How many times do you snack each day? _____
Do you have strong support and sufficient help from your family members and friends to maintain good health and proper diet? o yes o no

On the clocks below, please circle the times when you eat daily meals.
On the clocks below, please "x" the times when you normally snack.
Do you keep this consistent pattern of eating? o yes o no
If no, please explain: _____



12 a.m. – 11 a.m.



12 p.m. – 11 p.m.

SPECIAL DIETS:

Are you on a special diet? o yes o no
If yes, please explain: _____
_____

Is anyone in your family (those living with you) on a special diet? o yes o no
If yes, please explain: _____
_____
Does it affect your eating habits and/or diet? _____
_____

Do you have difficulty eating? o yes o no
If yes, please explain: _____
_____

Do you suffer from anorexia, bulimia, or compulsive eating? o yes o no
If yes, please explain and list foods: _____
_____

Do you turn to food as a way of coping with stress and/or depression?
o yes, always o yes, sometimes o no, never
If yes, please explain: _____
_____

Do you suffer from food allergies? o yes o no
If yes, please explain and list foods: _____
_____

SMOKING, DRINKING, DRUGS:

Do you smoke cigarettes? o yes o no If yes, please indicate frequency: _____
Do you drink alcohol? o yes o no If yes, please indicate frequency: _____
Do you take "street drugs"? o yes o no If yes, please indicate frequency: _____

CURRENT FOOD FREQUENCY CHECKLIST:

Food	**Servings, Amount & Frequency Per Day**	**Preparation Method**
Vegetables	_____	_____
	_____	_____
	_____	_____
	_____	_____
Fruits	_____	_____
	_____	_____
	_____	_____
	_____	_____
Animal Meats & Seafood	_____	_____
	_____	_____
	_____	_____
	_____	_____
Grains & Small Seeds	_____	_____
	_____	_____
	_____	_____
	_____	_____

Beans, Nuts & Large Seeds	_____	_____
	_____	_____
	_____	_____
	_____	_____
Dairy Products	_____	_____
	_____	_____
	_____	_____
	_____	_____
Water & Beverages	_____	_____
	_____	_____
	_____	_____
	_____	_____

The information I have provided is true and accurate to the best of my knowledge. I understand that this information will be held in strict confidentiality between the medical staff at Yeh Center of Natural Medicine, Inc. and myself.

The purpose of "Personalized Food Medicine" is to familiarize the patient with food medicine, nutrition, and diet on an individualized basis. The manual does not make any health claims, and the information introduced does not take the place of physician's care, medical procedures, lab tests, or any necessary medication.

Yeh Center of Natural Medicine, Inc. also does not in any way encourage any person to try to heal themselves or to stop their current medical care and supervision, as all medical treatment requires the knowledge and skill of a trained professional. Due to the personalized nature of this food medicine program, long hours are spent putting it together. Therefore, there is no exchange or refund for this book. I have read and understand the above statements.

Print Name: _____ Signature: _____ Date: _____