The Mediterranean Eating Study Phone Counseling Form

Date:_____Week:_____Name:_____ID:_____

1. How are you doing on the Mediterranean eating plan?

2. What are your biggest challenges?
   1._____
   2._____
   3._____

3. What did you do over the past week/weeks/month that has been the biggest help to you?

4. How many days on an average have you met you goals for:

High MUFA fats:	0 1 2 3 4 5 6 7	Alliums:	0 1 2 3 4 5 6 7
Vegetables:	0 1 2 3 4 5 6 7	Herbs:	0 1 2 3 4 5 6 7
Fruits:	0 1 2 3 4 5 6 7	High Omega 3 foods	0 1 2 3 4 5 6 7

5. On a scale of 0 to 7, **0** meaning you met no goal, **7** meaning you met all your goals, how would you say you've done? 0 1 2 3 4 5 6 7

6. How many days per week have you met most of your goals? 0 1 2 3 4 5 6 7

7. Have you weighed yourself : Y N Any changes in wt.? _____

8. Any health or medication changes?_____

9. Ideas for alleviating the challenges:

10. Participants location when called_____
11. Has Mediterranean Eating Plan booklet been read or looked over by participant? YES or NO

12. Follow up for next call:

Updated: 5/2010