

Client Name: _____

Date: _____

Please fill out two weeks days, and one day on a weekend, be as specific as you can and don't forget to write down extra's such as condiments and drinks or the odd sweet or piece of fruit. Keep this diary with you all day and write things down as you eat them rather than trying to do a recall at the end of the day.

Do not change your eating habits whilst keeping your food diary and ensure that you document ALL food and beverages consumed. If you leave things out it will provide an inaccurate reflection of your health and will interfere with my evaluation and treatment plan.

NOTE: Please document all water and other beverages drunk throughout the day.

Time	Quantity	Details of Food (Ingredients, organic or not, pre-packed, etc.)	Cooking Method	Where Eaten	Other Activity Whilst Eating	Mood
9am	1 medium bowl	Porridge made with skimmed milk, 6 dried apricots	Stove top	Standing	Getting kids to school	Rushed

Please list any symptoms (if any) you experienced during the day: _____

On a scale of 1 – 5 (1 being vertically stress-free) rate your overall stress level today:

1	2	3	4	5
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On a scale of 1 – 5 (1 being no energy) rate your overall energy level today:

1	2	3	4	5
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Where there any times during the day when you energy was particularly low or high? _____

List any exercise you performed today: _____

Food & Symptom Diary - Day Two

Time	Quantity	Details of Food (Ingredients, organic or not, pre-packed, etc.)	Cooking Method	Where Eaten	Other Activity Whilst Eating	Mood
9am	1 medium bowl	Porridge made with skimmed milk, 6 dried apricots	Stove top	Standing	Getting kids to school	Rushed

Please list any symptoms (if any) you experienced during the day: _____

On a scale of 1 – 5 (1 being vertically stress-free) rate your overall stress level today:

1	2	3	4	5
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On a scale of 1 – 5 (1 being no energy) rate your overall energy level today:

1	2	3	4	5
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Where there any times during the day when you energy was particularly low or high? _____

List any exercise you performed today: _____

Food & Symptom Diary - Day Three

Time	Quantity	Details of Food (Ingredients, organic or not, pre-packed, etc.)	Cooking Method	Where Eaten	Other Activity Whilst Eating	Mood
9am	1 medium bowl	Porridge made with skimmed milk, 6 dried apricots	Stove top	Standing	Getting kids to school	Rushed

Please list any symptoms (if any) you experienced during the day: _____

On a scale of 1 – 5 (1 being vertically stress-free) rate your overall stress level today:

1	2	3	4	5
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On a scale of 1 – 5 (1 being no energy) rate your overall energy level today:

1	2	3	4	5
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Where there any times during the day when you energy was particularly low or high? _____

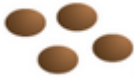







List any exercise you performed today: _____

Eliminations Diary

It is important to take note of the way the body is eliminating in order to gain a better understanding of the way the excretory pathways and organs of the body are working. Please place a tick or quantity where appropriate and comment if necessary. Fill this out the same days as you complete your food diary.

Bowels:

Please tick the box that most resembles your bowel motions.

Type 1	Type 2	Type 3	Type 4	Type 5	Type 6	Type 7	Type 8
							
Small hard pellets, like nuts (hard to pass)	Lumpy sausage shape	Sausage with cracks in surface	Smooth, soft, sausage shape	Soft blobs, clear-cut edges (passed easily)	Fluffy/mushy with ragged edges	Watery, no solid pieces, entirely liquid	Mucous, greasy/pale appearance
Day 1							
Day 2							
Day 3							

Please describe the frequency and colour of your bowel motions; also indicate if your bowel motions are odorous, float in the toilet, stick to the sides of the bowl, or contain mucous or blood.

Day 1:

Day 2:

























Day 3:

Urine:

How many times a day did you urinate:

Day 1:	
Day 2:	
Day 3:	

Indicate the general colour of your urine during the day (*not the first urine of the morning which will be darker*):

Sweat:

Do you ever experience any of the following (tick the appropriate box):

<input type="checkbox"/>	Noticeable sweating without heat or exercise
<input type="checkbox"/>	Hot sweats or flushes during the day
<input type="checkbox"/>	Hot sweats or flushes during the night

<input type="checkbox"/>	Odorous sweat
<input type="checkbox"/>	Sweating in unusual body areas
<input type="checkbox"/>	Don't sweat at all, even during exercise