

**SYMPTOM SURVEY FORM**  
(Restricted to Professional Use)

PATIENT \_\_\_\_\_ AGE \_\_\_\_\_ DOCTOR \_\_\_\_\_ DATE \_\_\_\_\_

**INSTRUCTIONS:** Circle the number that applies to you. If a symptom does not apply, leave it blank.  
Circle either: (1) for **MILD** symptoms (occurs rarely), (2) for **MODERATE** symptoms (occurs several times a month),  
or (3) for **SEVERE** symptoms (occurs almost constantly).

**GROUP ONE**

- |                                   |  |                                   |
|-----------------------------------|--|-----------------------------------|
| 1 - 1 2 3 Acid foods upset        | 8 - 1 2 3 Gag Easily                       | 15 - 1 2 3 Appetite reduced       |
| 2 - 1 2 3 Get chilled, often      | 9 - 1 2 3 Unable to relax, startles easily | 16 - 1 2 3 Cold sweats often      |
| 3 - 1 2 3 "Lump" in throat        | 10 - 1 2 3 Extremities cold, clammy        | 17 - 1 2 3 Fever easily raised    |
| 4 - 1 2 3 Dry mouth-eyes-nose     | 11 - 1 2 3 Strong light irritates          | 18 - 1 2 3 Neuralgia-like pains   |
| 5 - 1 2 3 Pulse speeds after meal | 12 - 1 2 3 Urine amount reduced            | 19 - 1 2 3 Staring, blinks little |
| 6 - 1 2 3 Keyed up - fail to calm | 13 - 1 2 3 Heart pounds after retiring     | 20 - 1 2 3 Sour stomach frequent  |
| 7 - 1 2 3 Cuts heal slowly        | 14 - 1 2 3 "Nervous" stomach               |                                   |

**GROUP TWO**

- |   |  |  |
|---|--|--|
| 21 - 1 2 3 Joint stiffness after arising                    | 29 - 1 2 3 Digestion rapid                       | 37 - 1 2 3 "Slow starter"                          |
| 22 - 1 2 3 Muscle-leg-toe cramps at night                   | 30 - 1 2 3 Vomiting frequent                     | 38 - 1 2 3 Get "chilled" infrequently              |
| 23 - 1 2 3 "Butterfly" stomach, cramps                      | 31 - 1 2 3 Hoarseness frequent                   | 39 - 1 2 3 Perspire easily                         |
| 24 - 1 2 3 Eyes or nose watery                              | 32 - 1 2 3 Breathing irregular                   | 40 - 1 2 3 Circulation poor,<br>sensitive to cold  |
| 25 - 1 2 3 Eyes blink often                                 | 33 - 1 2 3 Pulse slow; feels "irregular"         | 41 - 1 2 3 Subject to colds,<br>asthma, bronchitis |
| 26 - 1 2 3 Eyelids swollen, puffy                           | 34 - 1 2 3 Gagging reflex slow                   |  |
| 27 - 1 2 3 Indigestion soon after meals                     | 35 - 1 2 3 Difficulty swallowing                 |  |
| 28 - 1 2 3 Always seem hungry;<br>feels "lightheaded" often | 36 - 1 2 3 Constipation,<br>diarrhea alternating |  |

**GROUP THREE**

- |   |  |   |
|---|--|---|
| 42 - 1 2 3 Eat when nervous               | 49 - 1 2 3 Heart palpitates if meals<br>missed or delayed              | 53 - 1 2 3 Crave candy or coffee<br>in afternoons         |
| 43 - 1 2 3 Excessive appetite             | 50 - 1 2 3 Afternoon headaches   | 54 - 1 2 3 Moods of depression -<br>"blues" or melancholy |
| 44 - 1 2 3 Hungry between meals           | 51 - 1 2 3 Overeating sweets upsets                                    | 55 - 1 2 3 Abnormal craving for<br>sweets or snacks       |
| 45 - 1 2 3 Irritable before meals         | 52 - 1 2 3 Awaken after few hours sleep<br>- hard to get back to sleep |   |
| 46 - 1 2 3 Get "shaky" if hungry          |  |   |
| 47 - 1 2 3 Fatigue, eating relieves       |  |   |
| 48 - 1 2 3 "Lightheaded" if meals delayed |  |   |

**GROUP FOUR**

- |   |   |  |
|---|---|--|
| 56 - 1 2 3 Hands and feet go to sleep<br>easily, numbness | 63 - 1 2 3 Get "drowsy" often   | 68 - 1 2 3 Bruise easily, "black<br>and blue" spots  |
| 57 - 1 2 3 Sigh frequently, "air<br>hunger"               | 64 - 1 2 3 Swollen ankles<br>worse at night                                       | 69 - 1 2 3 Tendency to anemia  |
| 58 - 1 2 3 Aware of "breathing<br>heavily"                | 65 - 1 2 3 Muscle cramps, worse<br>during exercise; get<br>"charley horses"       | 70 - 1 2 3 "Nose bleeds" frequent  |
| 59 - 1 2 3 High altitude discomfort                       | 66 - 1 2 3 Shortness of breath<br>on exertion                                     | 71 - 1 2 3 Noises in head, or<br>"ringing in ears"   |
| 60 - 1 2 3 Opens windows in<br>closed room                | 67 - 1 2 3 Dull pain in chest or<br>radiating into left arm,<br>worse on exertion | 72 - 1 2 3 Tension under the<br>breastbone, or feeling<br>of "tightness",<br>worse on exertion |
| 61 - 1 2 3 Susceptible to colds<br>and fevers             |   |  |
| 62 - 1 2 3 Afternoon "yawner"                             |   |  |

**GROUP FIVE**

- |   |  |   |
|---|--|---|
| <b>73</b> - 1 2 3 Dizziness                                   | <b>83</b> - 1 2 3 Feeling queasy; headache over eyes           | <b>91</b> - 1 2 3 Sneezing attacks                    |
| <b>74</b> - 1 2 3 Dry skin                                    | <b>84</b> - 1 2 3 Greasy foods upset                           | <b>92</b> - 1 2 3 Dreaming, nightmare type bad dreams |
| <b>75</b> - 1 2 3 Burning feet                                | <b>85</b> - 1 2 3 Stools light-colored                         | <b>93</b> - 1 2 3 Bad breath (halitosis)              |
| <b>76</b> - 1 2 3 Blurred vision                              | <b>86</b> - 1 2 3 Skin peels on foot soles                     | <b>94</b> - 1 2 3 Milk products cause distress        |
| <b>77</b> - 1 2 3 Itching skin and feet                       | <b>87</b> - 1 2 3 Pain between shoulder blades                 | <b>95</b> - 1 2 3 Sensitive to hot weather            |
| <b>78</b> - 1 2 3 Excessive falling hair                      | <b>88</b> - 1 2 3 Use laxatives                                | <b>96</b> - 1 2 3 Burning or itching anus             |
| <b>79</b> - 1 2 3 Frequent skin rashes                        | <b>89</b> - 1 2 3 Stools alternate from soft to watery         | <b>97</b> - 1 2 3 Crave sweets                        |
| <b>80</b> - 1 2 3 Bitter, metallic taste in mouth in mornings | <b>90</b> - 1 2 3 History of gallbladder attacks or gallstones |   |
| <b>81</b> - 1 2 3 Bowel movements painful or difficult        |  |   |
| <b>82</b> - 1 2 3 Worrier, feels insecure                     |  |   |

**GROUP SIX**

- |  |  |  |
|--|--|--|
| <b>98</b> - 1 2 3 Loss of taste for meat                       | <b>101</b> - 1 2 3 Coated tongue   | <b>104</b> - 1 2 3 Mucous colitis or "irritable bowel" |
| <b>99</b> - 1 2 3 Lower bowel gas several hours after eating   | <b>102</b> - 1 2 3 Pass large amounts of foul-smelling gas                       | <b>105</b> - 1 2 3 Gas shortly after eating            |
| <b>100</b> - 1 2 3 Burning stomach sensations, eating relieves | <b>103</b> - 1 2 3 Indigestion 1/2 - 1 hour after eating; may be up to 3-4 hours | <b>106</b> - 1 2 3 Stomach "bloating" after eating     |

**GROUP SEVEN**

- |   |   |     |   |
|---|---|-----|---|
| <b>107</b> - 1 2 3 Insomnia                                   |   |     | (E)   |
| <b>108</b> - 1 2 3 Nervousness                                |   |     | <b>150</b> - 1 2 3 Dizziness                            |
| <b>109</b> - 1 2 3 Can't gain weight                          |   |     | <b>151</b> - 1 2 3 Headaches                            |
| <b>110</b> - 1 2 3 Intolerance to heat                        |   | (C) | <b>152</b> - 1 2 3 Hot flashes                          |
| <b>111</b> - 1 2 3 Highly emotional                           | <b>137</b> - 1 2 3 Failing memory                           |     | <b>153</b> - 1 2 3 Increased blood pressure             |
| <b>112</b> - 1 2 3 Flush easily                               | <b>138</b> - 1 2 3 Low blood pressure                       |     | <b>154</b> - 1 2 3 Hair growth on face or body (female) |
| <b>113</b> - 1 2 3 Night sweats                               | <b>139</b> - 1 2 3 Increased sex drive                      |     | <b>155</b> - 1 2 3 Sugar in urine (not diabetes)        |
| <b>114</b> - 1 2 3 Thin, moist skin                           | <b>140</b> - 1 2 3 Headaches, "splitting or rendering" type |     | <b>156</b> - 1 2 3 Masculine tendencies (female)        |
| <b>115</b> - 1 2 3 Inward trembling                           | <b>141</b> - 1 2 3 Decreased sugar tolerance                |     | (F)   |
| <b>116</b> - 1 2 3 Heart palpitates                           |   | (D) | <b>157</b> - 1 2 3 Weakness, dizziness                  |
| <b>117</b> - 1 2 3 Increased appetite without weight gain     | <b>142</b> - 1 2 3 Abnormal thirst                          |     | <b>158</b> - 1 2 3 Chronic fatigue                      |
| <b>118</b> - 1 2 3 Pulse fast at rest                         | <b>143</b> - 1 2 3 Bloating of abdomen                      |     | <b>159</b> - 1 2 3 Low blood pressure                   |
| <b>119</b> - 1 2 3 Eyelids and face twitch                    | <b>144</b> - 1 2 3 Weight gain around hips or waist         |     | <b>160</b> - 1 2 3 Nails, weak, ridged                  |
| <b>120</b> - 1 2 3 Irritable and restless                     | <b>145</b> - 1 2 3 Sex drive reduced or lacking             |     | <b>161</b> - 1 2 3 Tendency to hives                    |
| <b>121</b> - 1 2 3 Can't work under pressure                  | <b>146</b> - 1 2 3 Tendency to ulcers, colitis              |     | <b>162</b> - 1 2 3 Arthritic tendencies                 |
|   | <b>147</b> - 1 2 3 Increased sugar tolerance                |     | <b>163</b> - 1 2 3 Perspiration increase                |
| (B)   | <b>148</b> - 1 2 3 Women: menstrual disorders               |     | <b>164</b> - 1 2 3 Bowel disorders                      |
| <b>122</b> - 1 2 3 Increase in weight                         | <b>149</b> - 1 2 3 Young girls: lack of menstrual function  |     | <b>165</b> - 1 2 3 Poor circulation                     |
| <b>123</b> - 1 2 3 Decrease in appetite                       |   |     | <b>166</b> - 1 2 3 Swollen ankles                       |
| <b>124</b> - 1 2 3 Fatigue easily                             |   |     | <b>167</b> - 1 2 3 Crave salt                           |
| <b>125</b> - 1 2 3 Ringing in ears                            |   |     | <b>168</b> - 1 2 3 Brown spots or bronzing of skin      |
| <b>126</b> - 1 2 3 Sleepy during day                          |   |     | <b>169</b> - 1 2 3 Allergies - tendency to asthma       |
| <b>127</b> - 1 2 3 Sensitive to cold                          |   |     | <b>170</b> - 1 2 3 Weakness after colds, influenza      |
| <b>128</b> - 1 2 3 Dry or scaly skin                          |   |     | <b>171</b> - 1 2 3 Exhaustion - muscular and nervous    |
| <b>129</b> - 1 2 3 Constipation                               |   |     | <b>172</b> - 1 2 3 Respiratory disorders                |
| <b>130</b> - 1 2 3 Mental sluggishness                        |   |     |   |
| <b>131</b> - 1 2 3 Hair coarse, falls out                     |   |     |   |
| <b>132</b> - 1 2 3 Headaches upon arising wear off during day |   |     |   |
| <b>133</b> - 1 2 3 Slow pulse, below 65                       |   |     |   |
| <b>134</b> - 1 2 3 Frequency of urination                     |   |     |   |
| <b>135</b> - 1 2 3 Impaired hearing                           |   |     |   |
| <b>136</b> - 1 2 3 Reduced initiative                         |   |     |   |

GROUP EIGHT	FEMALE ONLY	MALE ONLY
173 - 1 2 3 Apprehension	200 - 1 2 3 Very easily fatigued	213 - 1 2 3 Prostate trouble
174 - 1 2 3 Irritability	201 - 1 2 3 Premenstrual tension	214 - 1 2 3 Urination difficult or dribbling
175 - 1 2 3 Morbid fears	202 - 1 2 3 Painful menses	215 - 1 2 3 Night urination frequent
176 - 1 2 3 Never seems to get well	203 - 1 2 3 Depressed feelings before menstruation	216 - 1 2 3 Depression
177 - 1 2 3 Forgetfulness	204 - 1 2 3 Menstruation excessive and prolonged	217 - 1 2 3 Pain on inside of legs or heels
178 - 1 2 3 Indigestion	205 - 1 2 3 Painful breasts	218 - 1 2 3 Feeling of incomplete bowel evacuation
179 - 1 2 3 Poor appetite	206 - 1 2 3 Menstruate too frequently	219 - 1 2 3 Lack of energy
180 - 1 2 3 Craving for sweets	207 - 1 2 3 Vaginal discharge	220 - 1 2 3 Migrating aches and pains
181 - 1 2 3 Muscular soreness	208 - 1 2 3 Hysterectomy/ovaries removed	221 - 1 2 3 Tire too easily
182 - 1 2 3 Depression; feelings of dread	209 - 1 2 3 Menopausal hot flashes	222 - 1 2 3 Avoids activity
183 - 1 2 3 Noise sensitivity	210 - 1 2 3 Menses scanty or missed	223 - 1 2 3 Leg nervousness at night
184 - 1 2 3 Acoustic hallucinations	211 - 1 2 3 Acne, worse at menses	224 - 1 2 3 Diminished sex drive
185 - 1 2 3 Tendency to cry without reason	212 - 1 2 3 Depression of long standing	
186 - 1 2 3 Hair is coarse and/or thinning		
187 - 1 2 3 Weakness		
188 - 1 2 3 Fatigue		
189 - 1 2 3 Skin sensitive to touch		
190 - 1 2 3 Tendency toward hives		
191 - 1 2 3 Nervousness		
192 - 1 2 3 Headache		
193 - 1 2 3 Insomnia		
194 - 1 2 3 Anxiety		
195 - 1 2 3 Anorexia		
196 - 1 2 3 Inability to concentrate; confusion		
197 - 1 2 3 Frequent stuffy nose; sinus infections		
198 - 1 2 3 Allergy to some foods		
199 - 1 2 3 Loose joints		

**IMPORTANT**

TO THE PATIENT: Please list below the five main physical complaints you have in order of their importance.

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

(TO BE COMPLETED BY DOCTOR)

Postural Blood Pressure: Recumbent \_\_\_\_\_ Standing \_\_\_\_\_ Pulse \_\_\_\_\_

Hema-Combistix Urine readings: pH \_\_\_\_\_ Albumin per cent \_\_\_\_\_ Glucose per cent \_\_\_\_\_

Occult Blood \_\_\_\_\_ pH of Saliva \_\_\_\_\_ pH of Stool specimen \_\_\_\_\_ Weight \_\_\_\_\_

Hemoglobin \_\_\_\_\_ Blood Clotting Time \_\_\_\_\_

**BARNES THYROID TEST**

This test was developed by Dr. Broda Barnes, M.D. and is a measurement of the underarm temperature to determine hypo and hyperthyroid states. The test is conducted by the patient in the a.m. before leaving bed - with the temperature being taken for 10 minutes. The test is invalidated if the patient expends any energy prior to taking the test - getting up for any reason, shaking down the thermometer, etc. It is important that the test be conducted for exactly 10 minutes, making the prior positioning of both the thermometer and a clock important.

**PRE-MENSES FEMALES AND MENOPAUSAL FEMALES**

Any two days during the month

**FEMALES HAVING MENSTRUAL CYCLES**

The 2<sup>nd</sup> and 3<sup>rd</sup> day of flow OR any 5 days in a row.

**MALES**

Any 2 days during the month.

You can do the following test at home to see if you may have a functional low thyroid. Use an oral thermometer or a digital one. When you use a digital one, place the probe under your arm for 5 minutes then turn your machine on; continue on for an additional 5 minutes. When using a regular one, shake down the night before.

Date: \_\_\_\_\_ Temperature: \_\_\_\_\_

Date: \_\_\_\_\_ Temperature: \_\_\_\_\_

Date: \_\_\_\_\_ Temperature: \_\_\_\_\_

Date: \_\_\_\_\_ Temperature: \_\_\_\_\_

Date: \_\_\_\_\_ Temperature: \_\_\_\_\_

Date: \_\_\_\_\_ Temperature: \_\_\_\_\_

BP SIT \_\_\_\_\_ BP STAND \_\_\_\_\_

PULSE SIT \_\_\_\_\_ PULSE STAND \_\_\_\_\_

SALIVA PH \_\_\_\_\_ BLOOD TYPE \_\_\_\_\_

CASE RECORD

Name \_\_\_\_\_ Date \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Age \_\_\_\_\_ Weight \_\_\_\_\_ Height \_\_\_\_\_ Sex \_\_\_\_\_

Occupation \_\_\_\_\_ Married \_\_\_\_\_

History of Illness and Treatment: \_\_\_\_\_

Operations, Accidents or Injuries: \_\_\_\_\_

Present Illness or Complaints: \_\_\_\_\_

Diagnostic Summary: \_\_\_\_\_

Treatment, Recommendations and Progress: \_\_\_\_\_

# SUBSTANCE SURVEY FORM

Name \_\_\_\_\_

Date \_\_\_\_\_

Please list any prescription medications you are currently taking or have taken in the last year:

Medications	Diagnosis
_____	_____
_____	_____
_____	_____
_____	_____

Please list any over-the-counter medications you are currently taking or have taken in the last year:

Product	Symptom	Quantity & Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any vitamins, supplements, herbs, or homeopathic medicines you are currently taking or have taken in the last year: (Use other side if needed.)

Product	Symptom	Quantity and Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____

Check the following items which apply to you and indicate the amount used:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Coffee _____           | <input type="checkbox"/> Artificial Sweetener _____ | <input type="checkbox"/> Ice Cream _____              |
| <input type="checkbox"/> Tea _____              | <input type="checkbox"/> Antacids _____             | <input type="checkbox"/> Alcohol _____                |
| <input type="checkbox"/> Soft Drinks _____      | <input type="checkbox"/> Laxatives _____            | <input type="checkbox"/> Cigarettes _____             |
| <input type="checkbox"/> Diet Soft Drinks _____ | <input type="checkbox"/> Candy _____                | <input type="checkbox"/> Other Tobacco Products _____ |

How many desserts do you have in an average week? \_\_\_\_\_

# Daily Record of Food Intake | Your diet may be the key to better health.

Each day, record all the items you eat and drink. Be sure to include the approximate amount of each item. When you have completed this form, return it to your health care professional for evaluation.



Name: \_\_\_\_\_

## Day 1 - Date: \_\_\_\_\_

<b>BREAKFAST</b> Time: _____	<b>LUNCH</b> Time: _____	<b>DINNER</b> Time: _____
Meat & Dairy: _____	_____	_____
Vegetables & Fruits: _____	_____	_____
Breads, Cereals, & Grains: _____	_____	_____
Fats (butter, margarine, oils, etc.): _____	_____	_____
Candy, Sweets, & Junk Food: _____	_____	_____
Water Intake (fl. oz.): _____	_____	_____
Other Drinks: _____	_____	_____
<b>MID-MORNING SNACK</b> Time: _____	<b>MID-DAY SNACK</b> Time: _____	<b>NIGHTTIME SNACK</b> Time: _____
Snack: _____	_____	_____
<b>Bowel Movements</b> (# and consistency): _____	<b>Hours of Sleep:</b> _____	<b>Quality of Sleep:</b> (good) 1 2 3 4 5 (poor)

## Day 2 - Date: \_\_\_\_\_

<b>BREAKFAST</b> Time: _____	<b>LUNCH</b> Time: _____	<b>DINNER</b> Time: _____
Meat & Dairy: _____	_____	_____
Vegetables & Fruits: _____	_____	_____
Breads, Cereals, & Grains: _____	_____	_____
Fats (butter, margarine, oils, etc.): _____	_____	_____
Candy, Sweets, & Junk Food: _____	_____	_____
Water Intake (fl. oz.): _____	_____	_____
Other Drinks: _____	_____	_____
<b>MID-MORNING SNACK</b> Time: _____	<b>MID-DAY SNACK</b> Time: _____	<b>NIGHTTIME SNACK</b> Time: _____
Snack: _____	_____	_____
<b>Bowel Movements</b> (# and consistency): _____	<b>Hours of Sleep:</b> _____	<b>Quality of Sleep:</b> (good) 1 2 3 4 5 (poor)

## Day 3 - Date: \_\_\_\_\_

<b>BREAKFAST</b> Time: _____	<b>LUNCH</b> Time: _____	<b>DINNER</b> Time: _____
Meat & Dairy: _____	_____	_____
Vegetables & Fruits: _____	_____	_____
Breads, Cereals, & Grains: _____	_____	_____
Fats (butter, margarine, oils, etc.): _____	_____	_____
Candy, Sweets, & Junk Food: _____	_____	_____
Water Intake (fl. oz.): _____	_____	_____
Other Drinks: _____	_____	_____
<b>MID-MORNING SNACK</b> Time: _____	<b>MID-DAY SNACK</b> Time: _____	<b>NIGHTTIME SNACK</b> Time: _____
Snack: _____	_____	_____
<b>Bowel Movements</b> (# and consistency): _____	<b>Hours of Sleep:</b> _____	<b>Quality of Sleep:</b> (good) 1 2 3 4 5 (poor)

Notes: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Day 4 - Date:**

**BREAKFAST** Time: \_\_\_\_\_

**LUNCH** Time: \_\_\_\_\_

**DINNER** Time: \_\_\_\_\_

Meat & Dairy: \_\_\_\_\_

Vegetables & Fruits: \_\_\_\_\_

Breads, Cereals, & Grains: \_\_\_\_\_

Fats (butter, margarine, oils, etc.): \_\_\_\_\_

Candy, Sweets, & Junk Food: \_\_\_\_\_

Water Intake (fl. oz.): \_\_\_\_\_

Other Drinks: \_\_\_\_\_

**MID-MORNING SNACK** Time: \_\_\_\_\_

**MID-DAY SNACK** Time: \_\_\_\_\_

**NIGHTTIME SNACK** Time: \_\_\_\_\_

Snack: \_\_\_\_\_

**Bowel Movements**(# and consistency): \_\_\_\_\_

**Hours of Sleep:** \_\_\_\_\_

**Quality of Sleep:** (good) 1 2 3 4 5 (poor)

**Day 5 - Date:**

**BREAKFAST** Time: \_\_\_\_\_

**LUNCH** Time: \_\_\_\_\_

**DINNER** Time: \_\_\_\_\_

Meat & Dairy: \_\_\_\_\_

Vegetables & Fruits: \_\_\_\_\_

Breads, Cereals, & Grains: \_\_\_\_\_

Fats (butter, margarine, oils, etc.): \_\_\_\_\_

Candy, Sweets, & Junk Food: \_\_\_\_\_

Water Intake (fl. oz.): \_\_\_\_\_

Other Drinks: \_\_\_\_\_

**MID-MORNING SNACK** Time: \_\_\_\_\_

**MID-DAY SNACK** Time: \_\_\_\_\_

**NIGHTTIME SNACK** Time: \_\_\_\_\_

Snack: \_\_\_\_\_

**Bowel Movements**(# and consistency): \_\_\_\_\_

**Hours of Sleep:** \_\_\_\_\_

**Quality of Sleep:** (good) 1 2 3 4 5 (poor)

**Day 6 - Date:**

**BREAKFAST** Time: \_\_\_\_\_

**LUNCH** Time: \_\_\_\_\_

**DINNER** Time: \_\_\_\_\_

Meat & Dairy: \_\_\_\_\_

Vegetables & Fruits: \_\_\_\_\_

Breads, Cereals, & Grains: \_\_\_\_\_

Fats (butter, margarine, oils, etc.): \_\_\_\_\_

Candy, Sweets, & Junk Food: \_\_\_\_\_

Water Intake (fl. oz.): \_\_\_\_\_

Other Drinks: \_\_\_\_\_

**MID-MORNING SNACK** Time: \_\_\_\_\_

**MID-DAY SNACK** Time: \_\_\_\_\_

**NIGHTTIME SNACK** Time: \_\_\_\_\_

Snack: \_\_\_\_\_

**Bowel Movements**(# and consistency): \_\_\_\_\_

**Hours of Sleep:** \_\_\_\_\_

**Quality of Sleep:** (good) 1 2 3 4 5 (poor)

**Day 7 - Date:**

**BREAKFAST** Time: \_\_\_\_\_

**LUNCH** Time: \_\_\_\_\_

**DINNER** Time: \_\_\_\_\_

Meat & Dairy: \_\_\_\_\_

Vegetables & Fruits: \_\_\_\_\_

Breads, Cereals, & Grains: \_\_\_\_\_

Fats (butter, margarine, oils, etc.): \_\_\_\_\_

Candy, Sweets, & Junk Food: \_\_\_\_\_

Water Intake (fl. oz.): \_\_\_\_\_

Other Drinks: \_\_\_\_\_

**MID-MORNING SNACK** Time: \_\_\_\_\_

**MID-DAY SNACK** Time: \_\_\_\_\_

**NIGHTTIME SNACK** Time: \_\_\_\_\_

Snack: \_\_\_\_\_

**Bowel Movements**(# and consistency): \_\_\_\_\_

**Hours of Sleep:** \_\_\_\_\_

**Quality of Sleep:** (good) 1 2 3 4 5 (poor)