

Name: _____

Dates: ___/___/___ to ___/___/___

Please indicate all foods, liquid, or other items ingested throughout the day along with the amounts of each.
Please include seasonings, condiments, supplements, gum, mints, etc... (basically everything).

DAY 1

Breakfast time:	Snack time:	Lunch time:	Snack time:	Dinner time:	Snack time:
Liquids consumed and amount of each:					
Energy level and time of day(energetic, tired, heavy, other):					
Other: supplements, medicine, gum or other miscellaneous items consumed:					
Bowel movements: #/day _____ Color _____ Smell: foul, no smell Any bloating or gas throughout the day? yes / no Circle if any apply: hard, loose, watery, difficult, easy, blood, mucous, undigested food, pain/discomfort –location _____					

DAY 2

Breakfast time:	Snack time:	Lunch time:	Snack time:	Dinner time:	Snack time:
Liquids consumed and amount of each:					
Energy level and time of day(energetic, tired, heavy, other):					
Other: supplements, medicine, gum or other miscellaneous items consumed:					
Bowel movements: #/day _____ Color _____ Smell: foul, no smell Any bloating or gas throughout the day? yes / no Circle if any apply: hard, loose, watery, difficult, easy, blood, mucous, undigested food, pain/discomfort –location _____					

Name: _____

Dates: ___/___/___ to ___/___/___

Please indicate all foods, liquid, or other items ingested throughout the day along with the amounts of each.
Please include seasonings, condiments, supplements, gum, mints, etc... (basically everything).

DAY 3

Breakfast time:	Snack time:	Lunch time:	Snack time:	Dinner time:	Snack time:
Liquids consumed and amount of each:					
Energy level and time of day(energetic, tired, heavy, other):					
Other: supplements, medicine, gum or other miscellaneous items consumed:					
Bowel movements: #/day _____ Color _____ Smell: foul, no smell Any bloating or gas throughout the day? yes / no Circle if any apply: hard, loose, watery, difficult, easy, blood, mucous, undigested food, pain/discomfort –location _____					

DAY 4

Breakfast time:	Snack time:	Lunch time:	Snack time:	Dinner time:	Snack time:
Liquids consumed and amount of each:					
Energy level and time of day(energetic, tired, heavy, other):					
Other: supplements, medicine, gum or other miscellaneous items consumed:					
Bowel movements: #/day _____ Color _____ Smell: foul, no smell Any bloating or gas throughout the day? yes / no Circle if any apply: hard, loose, watery, difficult, easy, blood, mucous, undigested food, pain/discomfort –location _____					