By Christine Dennis RH, MNIMH, MSc (Herb. Med.)

Diet/Lifestyle Diary Sheet

Name : _____ Date From: _____ Date To: _____

Please keep a record of everything you eat and drink, medications, supplements, smoking and water. Please note approximate amounts and time of day. Please, do NOT change your eating habits. Also list any symptoms you experience (ie. drowsiness, headaches, depression, bloating, etc.) and the time of day they occur.

Day 1 Temperature:_____

Time	Foods Eaten: Include everything	Feelings/Energy	Bowels/Urine	Sleep	Major Activities

Day 2 Temperature:_____

Time	Foods Eaten: Include everything	Feelings/Energy	Bowels/Urine	Sleep	Major Activities

Day 3 Temperature:_____

Time	Foods Eaten: Include everything	Feelings/Energy	Bowels/Urine	Sleep	Major Activities

Day 4 Temperature:_____

Time	Foods Eaten: Include everything	Feelings/Energy	Bowels/Urine	Sleep	Major Activities

Day 5 Temperature:_____

Time	Foods Eaten: Include everything	Feelings/Energy	Bowels/Urine	Sleep	Major Activities