

Health & Lifestyle Diary

Record the following for 1 week.
 Copy this form for the necessary days.
 Return to the Roberts Clinic for consultation.

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| <ul style="list-style-type: none"> <input type="checkbox"/> Foods & Liquids (qty, approx amnts, ...) <input type="checkbox"/> Digestive symptoms (bloat, gas, BM's, etc.) <input type="checkbox"/> Workouts (type, duration, intensity) | <ul style="list-style-type: none"> <input type="checkbox"/> Energy (scale of 1-10, low & high points daily) <input type="checkbox"/> Mood (draw ☺☹☺☹, note emotional changes) <input type="checkbox"/> Female cycle (start, duration, abnormalities) |
|---|--|

Date: _____

Typical day: y or n

	Food & Liquids	Digestive Sx	Energy Mood
1 st thing			
Breakfast			
Am snack			
Lunch			
Afternoon snack			
Dinner			
Pm snack			