DIET & SYMPTOM TRACKER **PATIENT NAME: _____**

Please use this chart to record all the food, beverages, supplements, and symptoms over the next week(s). Please be truthful. This is an invaluable tool in creating personalized treatment plans for you. If possible, try to include quantities and most of all have fun with this; it is as though you are your own doctor / researcher.

	Day 1	Day 2	Day 3
Breakfast			
Lunch			
Dinner			
Snacks			
Water (amount & time)			
Other drinks (types and amounts)			
Exercise (activity, intensity, type)			
Symptoms (pain, headaches, dizziness, fatigue, stomach pain, bowel movements, energy levels, sleep, etc.)			
Supplements			

	Day 4	Day 5	Day 6	Day 7
Breakfast				
Lunch				
Dinner				
Snacks				
Water (amount & time)				
Other drinks (types and amounts)				
Exercise (activity, intensity, type)				
Symptoms (pain, headaches, dizziness, fatigue, stomach pain, bowel movements, energy levels, sleep, etc.)				
Supplements				