DATE:

M T W T F S S

WEIGHT:

HOURS OF SLEEP:

WATER INTAKE

BREAKFAST:

LUNCH:

DINNER:

SNACK:

GUT HEALTH:

BLOATING (Y/N)

BOWEL MOVEMENT (TYPE, FREQUENCY, DISCOMFORT)

STOMACH PAIN (Y/N)

ACIDITY/HEARTBURN (Y/N)

NAUSEA (Y/N)

EXERCISE:

ENERGY LEVEL (1-10):

3 THINGS I AM GRATEFUL FOR TODAY:

1.

2.

3.

MOOD, SLEEP & STRESS:

MORNIGN MOOD:

EVENING MOOD:

SLEEP QUALITY (1-10)

STRESS LEVEL (1-10)

NOTES ON STRESS TRIGGERS:

PAIN SCALE (1-10):

MORNING PAIN LEVEL:

EVENING PAIN LEVEL:

AFFECTED AREAS:

NOTES ON RELIEF TECHNIQUES:

REFLECTION & GOALS:

1. WHAT WENT WELL TODAY?
2. WHAT CHALLENGES DID YOU FACE?
3. POSITIVE COPING TECHNIQUES USED
4. ONE THING I WILL IMPROVE TOMORROW
5. GOALS FOR TOMORROW (DIET, EXERCISE, STRESS MANAGEMENT)