NUTRITIONAL INTAKE

PLEASE MONITOR ALL OF THESE ITEMS TO THE BEST OF YOUR ABILITY FOR 1 WEEK

Food intake - Please be honest. Include all snacks, as well as full meals.

All drinks - Please differentiate between sweeteners (pop wit aspartame, tea with honey, etc.), also include alcohol, and coffee (again indicate sweeteners).

If possible, please list the sugar content of your beverages (# of sugar packets per cup of coffee, # of grams of sugar in your juice of pop, etc.)

Please list your favorites...what do you always keep stuffed away in the cabinets, your comfort foods, midnight snack, etc.

How many times a day do you eat?

PLEASE MAKE A NOTE IF THE FOOD YOU CONSUMED WAS FAST FOOD, AS WELL AS HOW IT WAS PREPARED (WAS IT FRIED FISH STICKS OR POACHED SALMON, DON'T JUST WRITE DOWN "FISH")

Bowel movements (# of times per day)

Urination (# of times per day)

Pain levels each day (on a scale of 1-10)

Please indicate any digestive difficulties you experience - Gas, bloating, acid reflux, constipation, etc.

Do you have any food allergies?

What is your blood type? (If you do not know your blood type, we will need to do a blood type test. This is offered at the clinic.)