RICHMOND HILL NATUROPATHIC CLINIC
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PATIENT NAME: ____________________ **START DATE:** ____________________

*Be sure to include approximate portions
* In "Comments" include symptoms such as headaches, stomach upset, sleeplessness etc., experienced that day

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
BREAKFAST							
LUNCH							
DINNER							
SNACKS							
WATER (circle # of glasses)	1 2 3 4 5 6 7 8 9 10 11 12	1 2 3 4 5 6 7 8 9 10 11 12	1 2 3 4 5 6 7 8 9 10 11 12	1 2 3 4 5 6 7 8 9 10 11 12	1 2 3 4 5 6 7 8 9 10 11 12	1 2 3 4 5 6 7 8 9 10 11 12	1 2 3 4 5 6 7 8 9 10 11 12
# BOWEL MOVEMENT(s)	0 1 2 3 4 ______	0 1 2 3 4 ______	0 1 2 3 4 ______	0 1 2 3 4 ______	0 1 2 3 4 ______	0 1 2 3 4 ______	0 1 2 3 4 ______
ENERGY / 10 (10=most energy)	______ / 10	______ / 10	______ / 10	______ / 10	______ / 10	______ / 10	______ / 10
COMMENTS							