

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_

Email: \_\_\_\_\_

Telephone: Home: \_\_\_\_\_ Work \_\_\_\_\_ Cell: \_\_\_\_\_

Profession: \_\_\_\_\_ Employer: \_\_\_\_\_

Married \_\_\_\_\_ Single \_\_\_\_\_ Divorced \_\_\_\_\_ Widow(er) \_\_\_\_\_ # of Children \_\_\_\_\_

Spouse's Name \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

I clearly understand that all services rendered me are my responsibility and payment is expected at the time of service.

Patient's Signature: \_\_\_\_\_

If under 18 years of age, parent or guardian's signature

\_\_\_\_\_

### **Nutritional Informed Consent**

According to the Federal Food, Drug, and Cosmetic Act, as amended, Section 201 (g) (1), the term "DRUG" is defined to mean: "Articles intended for use in the Diagnosis, Cure, Mitigation, Treatment or Prevention of disease." A vitamin is not a drug, NEITHER is a Mineral, Trace Element, Amino Acid, Herb, or Homeopathic Remedy. Although a Vitamin, a Mineral, Trace Element, Amino Acid, Herb or Homeopathic Remedy may have an effect on any disease process or symptoms, this does not mean that it can be misrepresented, or be classified as a drug by anyone. Therefore, please be advised that any suggested nutritional advice or dietary advice is not intended as a primary treatment and/or therapy for any disease or particular bodily symptom. Nutritional counseling, vitamin recommendations, nutritional advice, and the adjunctive schedule of nutrition is provided solely to upgrade the quality of foods in the patient's diet in order to supply good nutrition supporting the physiological and biomechanical processes of the human body. Nutritional advice and nutritional intake may also enhance the stabilization of chiropractic adjustments and treatment.

I have read and understand the above:

Signature \_\_\_\_\_

## PATIENT SYMPTOM SURVEY

DATE \_\_\_\_\_

PATIENT'S NAME \_\_\_\_\_ AGE \_\_\_\_\_

WEIGHT \_\_\_\_\_ HEIGHT \_\_\_\_\_ BLOOD PRESSURE \_\_\_\_\_ PULSE \_\_\_\_\_ O<sub>2</sub> \_\_\_\_\_

*This is a confidential patient symptom survey. Please check each condition which is true for you. Take your time. If you are not sure the condition applies to you or do not understand a term, do not check the box. Use common sense. For example, Insomnia once last month probably isn't that important and would not be marked. However, Insomnia 1-2 times per week is notable and would be marked. Please take your time...*

### Primary Complaints

- |   |   |  |
|---|---|--|
| <p>090 <input type="checkbox"/> General Good Health</p> <p>091 <input type="checkbox"/> Desires Nutritional &amp; Metabolic Analysis</p> <p>001 <input type="checkbox"/> Skin Disorder L25.9</p> <p>002 <input type="checkbox"/> Acne L70.8</p> <p>003 <input type="checkbox"/> Psoriasis L40.8</p> <p>004 <input type="checkbox"/> Urticaria (Hives) L50.9</p> <p>005 <input type="checkbox"/> ADD/ADHD F90.1/F90.9</p> <p>006 <input type="checkbox"/> Allergies, Unspecified J30.9</p> <p>007 <input type="checkbox"/> Allergic Rhinitis from food J30.5</p> <p>008 <input type="checkbox"/> Sinusitis J01.90</p> <p>009 <input type="checkbox"/> Alzheimer's G30.9</p> <p>010 <input type="checkbox"/> Poor Concentration/Memory F07.8</p> <p>011 <input type="checkbox"/> Parkinson's Disease G20</p> <p>012 <input type="checkbox"/> Anemia D64.9</p> <p>013 <input type="checkbox"/> Arthritic Disorder M12.9</p> <p>014 <input type="checkbox"/> Osteoporosis M81.0</p> <p>015 <input type="checkbox"/> Asthma J45.909</p> <p>016 <input type="checkbox"/> Emphysema J43.9</p> <p>017 <input type="checkbox"/> Cancer</p> <p style="padding-left: 20px;">018 <input type="checkbox"/> Breast C50.919female C50.929male</p> <p style="padding-left: 20px;">019 <input type="checkbox"/> Prostate C61</p> <p style="padding-left: 20px;">020 <input type="checkbox"/> Lung C34.90</p> <p style="padding-left: 20px;">021 <input type="checkbox"/> Colon and Rectal C18.9</p> <p style="padding-left: 20px;">022 <input type="checkbox"/> Skin C44.90</p> <p style="padding-left: 20px;">023 <input type="checkbox"/> Leukemia w/o remission C95.90<br/>Leukemia w/ remission C95.91</p> <p style="padding-left: 20px;">024 <input type="checkbox"/> Lymphoma, malignant C85.89</p> <p style="padding-left: 20px;">025 <input type="checkbox"/> Brain Tumor, malignant C71.9</p> <p>027 <input type="checkbox"/> Anxiety Disorder F41.9</p> <p>028 <input type="checkbox"/> Autism F84.0</p> <p>033 <input type="checkbox"/> Edema R60.9</p> <p>034 <input type="checkbox"/> Eczema L25.9</p> <p>035 <input type="checkbox"/> Chronic Fatigue R53.82</p> <p>036 <input type="checkbox"/> Circulatory Disorder I99.9</p> <p>037 <input type="checkbox"/> Heart Disease I51.9</p> <p>038 <input type="checkbox"/> High Cholesterol E78.0</p> | <p>039 <input type="checkbox"/> High Blood Pressure I10</p> <p>040 <input type="checkbox"/> Low Blood Pressure I95.9</p> <p>041 <input type="checkbox"/> Tachycardia<br/>(High Heart Rate) R00.0</p> <p>042 <input type="checkbox"/> Numbness R20.9</p> <p>043 <input type="checkbox"/> Constipation K59.00</p> <p>044 <input type="checkbox"/> Indigestion K30</p> <p>045 <input type="checkbox"/> Ulcerative Colitis K51.90</p> <p>046 <input type="checkbox"/> Depression F32.9</p> <p>047 <input type="checkbox"/> Diabetes Mellitus E11.9</p> <p>030 <input type="checkbox"/> Diabetes Type I E10.9</p> <p>031 <input type="checkbox"/> Diabetes Type II E11.65</p> <p>029 <input type="checkbox"/> Hyperglycemia<br/>[high blood sugar] R73.09</p> <p>048 <input type="checkbox"/> Hypoglycemia<br/>[low blood sugar] E16.2</p> <p>049 <input type="checkbox"/> Dizziness/Balance Problem<br/>R42</p> <p>050 <input type="checkbox"/> Ear Infection H65.90</p> <p>051 <input type="checkbox"/> Epstein Barr B27.90</p> <p>052 <input type="checkbox"/> Eye Problems H57.13</p> <p>053 <input type="checkbox"/> Cataracts H26.9</p> <p>054 <input type="checkbox"/> Glaucoma H40.9</p> <p>055 <input type="checkbox"/> Macular Degeneration H35.30</p> <p>056 <input type="checkbox"/> Fever R50.9</p> <p>057 <input type="checkbox"/> Fibromyalgia M79.7</p> <p>058 <input type="checkbox"/> Gallbladder Disorder K82.9</p> <p>059 <input type="checkbox"/> Gout M10.9</p> <p>060 <input type="checkbox"/> Headaches R51</p> <p>061 <input type="checkbox"/> Hearing Loss H91.90</p> <p>062 <input type="checkbox"/> Infertility, male N46.9</p> <p>064 <input type="checkbox"/> Liver Disease K76.9</p> <p style="padding-left: 20px;">065 <input type="checkbox"/> Hepatitis K71.6</p> <p style="padding-left: 20px;">066 <input type="checkbox"/> Hepatitis B B16.9</p> <p style="padding-left: 20px;">067 <input type="checkbox"/> Hepatitis C B17.10</p> <p>068 <input type="checkbox"/> Kidney Disorder N28.9 or<br/>Bladder Disorder N32.9</p> | <p>063 <input type="checkbox"/> Prostate Disorder N42.9</p> <p>069 <input type="checkbox"/> Hyperthyroidism E05.90</p> <p>070 <input type="checkbox"/> Hypothyroidism E03.9</p> <p>071 <input type="checkbox"/> Systemic Lupus M32.10</p> <p>072 <input type="checkbox"/> Infertility, female M97.9</p> <p>073 <input type="checkbox"/> Interstitial Cystitis N30.11</p> <p>074 <input type="checkbox"/> Irregular Menstrual Cycle N92.6</p> <p>075 <input type="checkbox"/> Menopausal Symptoms N95.1</p> <p>076 <input type="checkbox"/> Hot Flashes N95.1</p> <p>077 <input type="checkbox"/> Mental Disorder F99</p> <p>078 <input type="checkbox"/> Insomnia G47.00</p> <p>079 <input type="checkbox"/> Mouth/Throat/Tongue</p> <p>080 <input type="checkbox"/> Canker Sores K12.0</p> <p>081 <input type="checkbox"/> Overweight E66.3</p> <p>082 <input type="checkbox"/> Underweight R63.6</p> <p>083 <input type="checkbox"/> Sexual Disorder F66</p> <p>084 <input type="checkbox"/> Spinal Problems M53.9</p> <p>085 <input type="checkbox"/> Obesity E66.9</p> <p>086 <input type="checkbox"/> GERD K21.9</p> <p>087 <input type="checkbox"/> HIV B20</p> <p>088 <input type="checkbox"/> Crohn's Disease K50.90</p> <p>089 <input type="checkbox"/> Irritable Bowel Syndrome K58.9</p> <p>092 <input type="checkbox"/> Normal Pregnancy Z33.1<br/><i>**only applicable if currently pregnant</i></p> <p>093 <input type="checkbox"/> Shingles B02.9</p> <p>140 <input type="checkbox"/> Migraines G43.909</p> <p>141 <input type="checkbox"/> Rheumatoid Arthritis M06.9</p> <p>142 <input type="checkbox"/> Non-Systemic Lupus L93.0</p> <p>143 <input type="checkbox"/> Multiple Sclerosis G35</p> <p>144 <input type="checkbox"/> ALS (Lou Gehrig's) G12.21</p> <p>145 <input type="checkbox"/> Polymyalgia Rheumatica M35.3</p> <p>146 <input type="checkbox"/> Scleroderma M34.9</p> <p>171 <input type="checkbox"/> Goiter E04.9</p> <p>178 <input type="checkbox"/> Raynaud's Syndrome I73.00</p> <p>179 <input type="checkbox"/> Hemochromatosis E83.119</p> <p>180 <input type="checkbox"/> Thalassemia D56.8</p> <p>181 <input type="checkbox"/> Brain aneurysm I61.9</p> |
|---|---|--|

**If necessary, please state your most significant concern...**

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## General Health

- 100  Fingernail base is pink  
101  Fingernail base is purple  
102  Fingernails have ridges or white spots  
103  Fingernails are soft  
104  Fingernails are splitting  
105  Fingernails peel  
106  Pale fingernail beds  
107  Blacks out easily  
108  Balance problems  
109  Difficulty walking  
110  Has tattoos  
111  Brittle hair  
112  Dry hair  
113  Thin hair  
114  Hair loss  
115  Drinks alcoholic beverages daily  
116  Drinks less than 8 glasses of water per day  
117  Currently on Chemotherapy  
118  Currently on radiation treatment  
119  Had chemotherapy in the past  
120  Has had radiation treatments in the past  
121  Gained over 20 lbs in the last 12 months  
122  Somewhat Overweight  
123  Somewhat Underweight
- 124  Unexplained loss of >20lbs in last 4 months  
125  Energy level is worse than it was 5 years ago  
127  Sleeps less than 6 hours per night  
128  Unable to recall dreams the next day  
129  Sensitive to chemicals, paint, fumes, cologne  
130  Had blood transfusion in the past  
131  Had transplant in the past  
138  Takes anti-rejection drugs  
132  Had a major accident or injury  
137  Sleep Apnea  
139  Toxic chemical exposure  
175  Has been out of the country recently  
176  Had childhood vaccines  
177  Had a vaccine in the last 12 months  
147  Had a flu shot last year  
182  Had a pneumonia vaccine last year  
183  Had a Hepatitis B vaccine in the last 2 years.
- Has a family history of:
- 184  Cancer  
185  Heart Disease  
186  Diabetes  
187  Alcoholism  
188  Depression  
189  Obesity

## Lifestyle & Environment

- Do you use?  Well Water  City Water Filtered?  Yes  No Filter Type? \_\_\_\_\_  
What kind of pipes are in your home?  Steel  CPVC  Copper  Pex  Other \_\_\_\_\_  
What year was your home built? \_\_\_\_\_ Any renovations in the past year? \_\_\_\_\_  
Do you use chlorine bleach or other heavy duty cleaners in your home/work?  Yes  No  
Have you ever worked around heavy machinery, plumbing, automotive or the metallurgic industry?  Yes  No  
Explain: \_\_\_\_\_  
Have you ever worked around industrial solvents, chemicals or pesticides?  Yes  No  
Explain: \_\_\_\_\_

- 380  Drinks beverages from a can  
370  Drinks alcohol  
371  Drinks caffeinated coffee  
372  Drinks caffeinated pop/soda  
373  Drinks caffeinated tea  
374  Drinks decaffeinated coffee  
375  Drinks decaffeinated pop/soda  
376  Drinks decaffeinated tea  
377  Drinks >3 cups of coffee daily  
378  Drinks >3 cups of tea per day  
388  Drinks diet pop/soda
- 379  Drinks >1 pop/sodas per day  
I had 4 alcoholic drinks in one day:  
172  never  
173  more than 3 months ago  
174  less than 3 months ago  
381  Has >5 alcoholic drinks/week  
391  Craves sugar / starches  
382  Currently smokes  
383  Quit smoking in last 5 years  
384  Smoked for >5 years  
385  Smokes >1 pack per day
- 126  Rarely exercises  
133  Regularly exercises  
386  Takes Vitamins  
134  Vegetarian  
135  Eats no red meat  
136  Eats no meat, no dairy  
387  Frequent use of artificial sweeteners  
389  Anorexia  
390  Bulimic

## Surgeries

- 700  Tonsillectomy and/or Adenoids
- 701  Appendix
- 702  Gallbladder
- 703  Thyroid
- 704  Hysterectomy, complete
- 705  Hysterectomy, partial
- 706  Tubal ligation
- 707  Breast implants
- 708  Cancer
- 709  Coronary by-pass
- 710  Spinal surgery
- 711  Extremity surgery
- 712  Hip replacement
- 713  Knee replacement
- 714  Splenectomy
- 715  Radiated thyroid
- 716  Cataract surgery
- 717  Hemorrhoidectomy
- 718  Bariatric/Weight loss

Type: \_\_\_\_\_

## Gastrointestinal

- 265  4-5 bowel movements per week
- 266  3 or less bowel movements per week
- 267  6 or more bowel movements per week
- 268  Black tarry stools
- 269  Pale or yellow colored stool
- 270  Blood stools
- 271  Constipation
- 272  Hemorrhoids
- 273  Loose bowel movements
- 274  Frequent diarrhea
- 275  Frequent nausea
- 276  Frequent vomiting
- 277  Abdominal gas
- 278  Belching and burping after eating
- 279  Bloating after eating
- 280  Severe abdominal pains
- 281  Stomach ulcers
- 282  Uses digestive aids
- 283  Uses laxatives
- 284  Immediate indigestion upon eating
- 285  Indigestion in 2 hours or more after meals
- 286  Indigestion within 1 hour after meals
- 287  Difficulty swallowing
- 288  Eating relieves fatigue
- 289  Eats when nervous
- 290  Excessive hunger
- 291  Poor appetite
- 292  Experiences fainting spells when hungry
- 293  Feels shaky when hungry
- 294  Frequently drowsy after eating a meal
- 295  Gall bladder disease
- 296  Has had intestinal worms
- 297  Reflux/Hiatal hernia
- 298  Liver disease
- 299  Irritable Bowel Syndrome
- 300  Diverticulitis
- 301  Diverticulosis

## Respiratory

- 485  Catches severe colds
- 486  Chronic chest condition
- 487  Chronic cough
- 488  Constant runny nose
- 489  COPD
- 490  Difficulty breathing
- 491  Frequent colds
- 492  Frequent nose bleeds
- 493  Frequent sinus infections
- 494  Frequent stuffy nose
- 495  Hay fever
- 496  Nasal polyps
- 497  Night sweats
- 498  Post nasal drip
- 499  Sneezing spells
- 500  Spits up blood
- 501  Spits up phlegm
- 502  Wheezes

## Mouth and Throat

- 400  Bad breath
- 401  Bitter taste in the mouth  
in the morning
- 402  Dry mouth
- 403  Excessive saliva
- 404  Sores or cracks in the  
corners of the mouth
- 405  Glands often swell
- 406  Frequent canker sores
- 407  Frequent fever blisters
- 408  Frequent sore throats
- 409  Frequently has a sore  
tongue
- 410  Sore gums
- 411  Swollen gums
- 412  Swollen tongue
- 413  Tongue burns
- 414  Tongue has grooves or fissures
- 415  Tongue is coated
- 416  Gums bleed when brushing teeth
- 417  Toothaches
- 418  Amalgam dental fillings
- 420  Other dental fillings  
(gold, composite, etc)
- 419  Has had root canal(s)

## Endocrine

- 245  Coarse hair  
246  Coarse skin  
247  Diabetic  
248  Excessive thirst  
249  Frequently feels cold  
250  Frequently feels hot  
251  Gets lightheaded when standing quickly  
252  Heals slowly  
253  Unusually jumpy or nervous  
254  Unusually tired most of the time

## Cardiovascular

- 190  Cold feet  
191  Cold hands  
192  Experiences shortness of breath while sitting still  
193  Heart skips beats  
194  Tendency of High blood pressure  
195  Leg cramps during bedtime  
196  Leg cramps during daytime  
197  Low blood pressure at times  
198  Pain in leg/hips when walking  
199  Frequent swollen ankles  
200  Pains in the heart or chest  
201  Spells of rapid heart rate  
202  Troubled with blood clots  
203  Unusually slow pulse rate  
204  Varicose veins  
205  Heart palpitations

## Skin

- 520  Bruises easily  
521  Excessive perspiration  
522  Frequent goose bumps  
523  Has acne  
524  Has Psoriasis  
525  Hives  
526  Itchy skin  
527  Problems with Eczema  
528  Has moles which are changing in size and/or color  
530  Skin is rough, especially on the back of the arms  
529  Skin eruptions  
531  Skin is tender  
532  Sores that heal slowly  
533  Troubled with boils  
534  Dry skin

## Ears

- 220  Discharge from ears  
221  Hard of hearing  
222  Punctured ear drum  
223  Recurrent ear infection  
224  Ringing or noises in the ears  
225  Tinnitus

## Eyes

- 320  Bloodshot eyes  
321  Blurred vision  
322  Cross eyes  
323  Eye pain  
324  Eyes feel gritty  
325  Eyes watery  
326  Mild Glaucoma  
327  Far sighted  
328  Developing cataracts  
329  Mild Macular degeneration  
330  Itchy eyes  
331  Near sighted  
332  Dry Eyes

## Feet

- 350  Corns  
351  Frequent foot cramps  
352  Heel spurs  
353  Painful feet  
354  Plantar warts  
355  Swelling in the feet and/or ankles  
356  Plantar fasciitis  
357  Fungal Infection

## Neuromuscular

- 440  Bites nails  
441  Frequent muscle soreness  
442  Muscle spasms  
443  Muscle weakness  
444  Tremors  
445  Frequent headaches  
446  Often dizzy  
447  Frequently feels faint  
448  Has Epilepsy  
449  Has motion sickness  
450  Has Osteoarthritis  
451  Has Rheumatism  
452  Rheumatoid Arthritis  
453  Joint stiffness in the morning  
454  Swollen joints  
455  Leg pain at rest  
456  Spinal curvature  
457  Low back pain  
458  Neck pain  
459  Pain between the shoulders  
460  Shoulder/arm pain  
461  Numbness/tingling in the body  
462  Sleep walks  
463  Stutters or stammers  
464  Nerve pain

## Behavior Patterns

- 150  Afraid to eat anywhere except home
- 151  Always needs someone to advise
- 152  Cries often
- 153  Difficulty concentrating
- 154  Difficulty falling asleep
- 155  Difficulty staying asleep
- 156  Easily angered
- 157  Feelings are easily hurt
- 158  Frequently becomes scared for no reason
- 159  Frequently miserable or blue
- 160  Has to be on guard even with friends
- 161  Often annoyed by people
- 162  Recurrent bad dreams
- 163  Sometimes wishes to be dead or away from it all
- 164  Upset by criticism
- 165  Poor memory
- 166  Scared to be alone
- 167  Strange people or places cause fear
- 168  Under considerable emotional stress
- 169  Unhappy when others are happy
- 170  Brain fog

## Urinary

- 555  Urinates more than 2 times per night
- 556  Bed wetting
- 557  Blood in the urine
- 558  Difficulty starting urination
- 559  Painful urination
- 560  Frequent urination
- 561  Troubled by urgent urination
- 562  Incontinence when sneezing or laughing
- 563  Loses bladder control
- 564  Frequent bladder infections
- 565  Frequent kidney infections
- 566  Kidney stones

## Men Only

- 585  Difficulty completing intercourse
- 586  Difficulty getting or keeping an erection
- 587  Discharge from the urethra
- 588  Had a vasectomy
- 589  Had difficulty fathering children
- 590  Lumps in the testicles
- 591  Painful genitals
- 592  Prostate troubles
- 593  Sores on external genitalia
- 594  Herpes
- 595  Sexual diseases

## Women Only

- 610  Heavy hair growth on face or body
- 611  Cycles are every 27-29 days
- 612  Abnormal cycle >29 days and/or <26 days
- 613  PMS
- 614  Menstrual cramps
- 615  Painful periods
- 616  Acne worse at menstruation
- 617  Excessive menstrual flow
- 618  Retains fluid during periods
- 619  Pre-menstrual depression
- 620  Currently taking birth control medication
- 621  Has taken birth control medication more than 1 year
- 622  Has taken birth control medication within the last year
- 623  Has had miscarriage
- 624  Hot flashes
- 625  Takes hormone replacement medication
- 627  Diminished sexual desire
- 628  Painful intercourse
- 629  Poor or infrequent orgasm
- 630  Lumps in the breasts
- 631  Tender breasts
- 633  Vaginal discharge
- 634  Bloody spotting discharge
- 635  Yeast infections
- 636  Sores on external genitalia
- 637  Herpes
- 638  Sexual diseases
- 639  Endometriosis
- 640  Breast reduction
- 641  Breast augmentation
- 642  Abortion
- 643  D&C
- 644  Tubal pregnancy
- 645  Uterine fibroids
- 646  Ovarian fibroids
- 647  Breast fibroids
- 648  Currently Breastfeeding

## Medications

Please list all drugs you are currently taking on a daily basis.

<u>DRUG</u>	<u>PRESCRIBED FOR:</u>	<u>HOW LONG</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list all drugs taken within the last year and/or you take as needed including over the counter drugs, antibiotics, aspirin, inhalers, etc.

<u>DRUG</u>	<u>PRESCRIBED FOR:</u>	<u>HOW LONG</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

## Allergies

Please list any known allergies (ex. foods, medications, spices, environmental, etc.)

- |                                      |                                 |                                    |                                      |
|--------------------------------------|---------------------------------|------------------------------------|--------------------------------------|
| <input type="checkbox"/> Dairy       | <input type="checkbox"/> Gluten | <input type="checkbox"/> Ragweed   | <input type="checkbox"/> Sulfa drugs |
| <input type="checkbox"/> Eggs        | <input type="checkbox"/> Mold   | <input type="checkbox"/> Shellfish | <input type="checkbox"/> Tree nuts   |
| <input type="checkbox"/> Garlic      | <input type="checkbox"/> Peanut | <input type="checkbox"/> Soy       | <input type="checkbox"/> Wheat       |
| <input type="checkbox"/> Other _____ |                                 |                                    |                                      |

## Supplements

Please list all vitamins/herbs/supplements you are currently taking and dosages.

<u>VITAMIN</u>	<u>BRAND</u>	<u>DOSAGE</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Daily Food Diary for \_\_\_\_\_ Date \_\_\_\_\_**

Food Type	How Much? Baked, Boiled, Grilled, Fried or Zapped? Brand Name?
<b>Breakfast TIME?</b>	
<b>Supplements (name &amp; dosage)?</b>	
<b>Comments</b>	
<b>Snack TIME?</b>	
<b>Lunch TIME?</b>	
<b>Supplements (name &amp; dosage)?</b>	
<b>Comments</b>	
<b>Snack TIME?</b>	
<b>Dinner TIME?</b>	
<b>Supplements (name &amp; dosage)?</b>	
<b>Comments</b>	
<b>Snack TIME?</b>	

**Water (~10oz)**



**Other Beverages**

**Exercise**

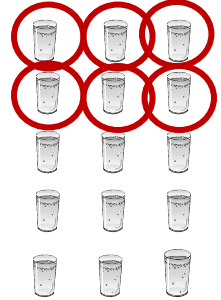


Daily Food Diary for Your Name Here

Date 07/01/09

Food Type	How Much? Baked, Boiled, Grilled, Fried or Zapped? Brand Name?
<b>Breakfast TIME? 7a</b>	
2 eggs	Sunny side up; organic
1 slice toast	Brownberry whole grain toast; Earth Balance butter spread
1 med banana	Conventional (not organic)
<b>Supplements (name &amp; dosage)? Solaray Multiple 2</b>	
<b>Comments</b> I felt a little nauseated after taking my vitamins this morning.	
<b>Snack TIME?</b>	
none	
<b>Lunch TIME? 1p</b>	
Salad (~ 3 cups)	Mixed lettuces, chicken, pecans, carrots, celery w/ Vinaigrette dressing
Tomato Soup	Organic, no dairy
<b>Supplements (name &amp; dosage)? none</b>	
<b>Comments</b> none	
<b>Snack TIME? 3p</b>	
1 med Hershey Bar	
<b>Dinner TIME? 6:30p</b>	
Lasagna	Homemade; Kraft cheeses, Ragu sauce, Store brand noodles, (2 helpings)
Steamed corn	Green Giant brand, 1/2 cup
Texas Toast	Store brand; 2 slices
<b>Supplements (name &amp; dosage)? Solaray Multiple 2</b>	
<b>Comments</b> I felt really tired this afternoon.	
<b>Snack TIME? 9p</b>	
Ice cream	Chocolate chunk; 1 cup

**Water (~10oz)**



**Other Beverages**

4 oz Green Tea

**Exercise**

-Cardio:  
Ran 3 miles

-Weight Training:  
Arms and Abs