blum MD CENTER FOR HEALTH

Blum Center For Health
34 Rye Ridge Plaza
Rye Brook, NY 10573
914-652-7800

Patient Intake Form

Welcome to Blum Center for Health! This is the first step on your path to wellness and we look forward to meeting with you in person.

We have created this comprehensive intake form for you to fill out in advance of coming to see us. We realize it might take some time for you to go through, but this will give you an opportunity to think and remember about your past medical history, about your current medical concerns and reasons for seeking our help. Having all this information on paper will be very helpful when you come in, and we will review this together during your medical or nutrition consultation. We have learned that it is often hard for our patients to remember everything when sitting in front of us!

See you soon,

Susan S. Blum, MD, MPH
Medical Director

Elizabeth Greig, MSN, FNP
Nurse Practitioner, Functional Medicine

Mary Gocke, RD
Nutritionist, Functional Medicine

* We ask that you please refrain from wearing perfume, cologne, or scented body lotions at the time of your visit since we have many patients with severe allergies. Thank you in advance for your consideration.

SECTION 1: PATIENT INFORMATION

Name			Date
Age	Date Of Birth	Social Security #	Gender
Occupation			

Primary Address			Alternate Address		
Street			Street		
City	State	Zip	City	State	Zip
Home Phone			Work Phone		
Cell Phone			Fax		
Email Address			Permission to leave a message on your answering machine? ◯ Yes ◯ No		
Emergency Contact			Emergency Phone:		

Referred by: Book Website Media Friend or Family

Other _____

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INSURANCE INFORMATION

Member Name | ◯ Self ◯ Spouse ◯ Parent

Name of Insurer | State | Plan #

Insurance Claims: We do not accept insurance. We are out of network for all private insurance and opted-out of Medicare. We will provide you with an insurance form for you to submit. We are not responsible for any billing issues between you and your insurance carrier after your appointment. Therefore, any issues with your insurance claim, must be handled by the patient directly

SECTION 2: MEDICAL HISTORY

What brings you to Blum Center For Health? _____

_____

_____

If you had 3 wishes for our visit today, what would they be?

_____

_____

_____

When did you last feel well? _____

_____

_____

_____

_____

_____

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SYMPTOM REVIEW

Please check if you have had these symptoms in the past and/or in the recent 6 months (including now)

SKIN PROBLEMS:

NOW	PAST	
☐	☐	Acne
☐	☐	Athlete's foot
☐	☐	Bumps back of upper arms
☐	☐	Cellulite
☐	☐	Dandruff
☐	☐	Dark circles under eyes
☐	☐	Ears get red
☐	☐	Easy bruising
☐	☐	Eczema
☐	☐	Herpes – genital
☐	☐	Cold sores
☐	☐	Hives
☐	☐	Jock itch
☐	☐	Change in Moles
☐	☐	Oily skin
☐	☐	Psoriasis
☐	☐	Rash
☐	☐	Red face
☐	☐	Sensitive to bites
☐	☐	Sensitive to poison ivy/oak
☐	☐	Shingles
☐	☐	Skin cancer
☐	☐	Skin itching
☐	☐	Skin dryness
☐	☐	Strong body odor

HEAD, EYES & EARS:

NOW	PAST	
☐	☐	Distorted smell
☐	☐	Distorted taste
☐	☐	Bad Breath
☐	☐	Ear fullness
☐	☐	Ear pain
☐	☐	Ear ringing
☐	☐	Hearing prob
☐	☐	Eye pain
☐	☐	Vision
☐	☐	Sinus
☐	☐	Migraine
☐	☐	Headache
☐	☐	Noise sensitive
☐	☐	Jaw pain

NAILS:

NOW	PAST	
☐	☐	Bitten
☐	☐	Brittle
☐	☐	Curve up
☐	☐	Fungus
☐	☐	Peeling
☐	☐	Ridges
☐	☐	Thickened
☐	☐	White spots/lines

CARDIOVASCULAR:

NOW	PAST	
☐	☐	Chest pain
☐	☐	Breathlessness
☐	☐	Palpitations
☐	☐	Pain in calves
☐	☐	Swollen ankles
☐	☐	Varicose veins

RESPIRATORY:

NOW	PAST	
☐	☐	Bad breath
☐	☐	Cough
☐	☐	Hay fever
☐	☐	Hoarseness
☐	☐	Nasal stuffiness
☐	☐	Nose bleeds
☐	☐	Post nasal drip
☐	☐	Out of breath
☐	☐	At rest
☐	☐	With exercise
☐	☐	Sinus fullness
☐	☐	Sinus infection
☐	☐	Snoring
☐	☐	Sore throat
☐	☐	Wheezing
☐	☐	Winter stuffiness

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DIGESTION:

NOW PAST

- ☐ ☐ Bloating after eating
- ☐ ☐ Blood in stools
- ☐ ☐ Burping
- ☐ ☐ Constipation
- ☐ ☐ Anal itching
- ☐ ☐ Trouble chewing
- ☐ ☐ Diarrhea
- ☐ ☐ Difficulty swallowing
- ☐ ☐ Dry mouth
- ☐ ☐ Passing gas
- ☐ ☐ Fissures
- ☐ ☐ Foods “repeat”
- ☐ ☐ Heartburn (reflux)
- ☐ ☐ Hemorrhoids
- ☐ ☐ Intolerance to:
  - ☐ ☐ Lactose
  - ☐ ☐ All milk products
  - ☐ ☐ Gluten
  - ☐ ☐ Corn
  - ☐ ☐ Eggs
  - ☐ ☐ Fatty foods
  - ☐ ☐ Other_____
- ☐ ☐ Yellow eyes/skin
- ☐ ☐ Abdominal pain
- ☐ ☐ Mucus in stools
- ☐ ☐ Nausea
- ☐ ☐ Strong stool odor
- ☐ ☐ Undigested food in stools
- ☐ ☐ Vomiting

MUSCLE/BONE:

NOW PAST

- ☐ ☐ Muscle twitching
- ☐ ☐ Muscle pain
- ☐ ☐ Joint pain
- ☐ ☐ Joint stiffness
- ☐ ☐ Tendonitis
- ☐ ☐ Back pain

MOOD/NERVES:

NOW PAST

- ☐ ☐ Difficulty:
- ☐ ☐ Concentrating
- ☐ ☐ With balance
  - ☐ ☐ With judgment
  - ☐ ☐ With memory
- ☐ ☐ Dizziness (spinning)
- ☐ ☐ Light headedness
- ☐ ☐ Fainting
- ☐ ☐ Numbness
- ☐ ☐ Anxiety
- ☐ ☐ Fearfulness
- ☐ ☐ Depression
- ☐ ☐ Suicidal thoughts
- ☐ ☐ Other Phobias
- ☐ ☐ Panic attacks
- ☐ ☐ Paranoia
- ☐ ☐ Hallucinations
- ☐ ☐ Seizures
- ☐ ☐ Tingling
- ☐ ☐ Tremor

ENDOCRINE/IMMUNE

NOW PAST

- ☐ ☐ Cold hands/ feet
- ☐ ☐ Cold or heat intolerance
- ☐ ☐ Fatigue
- ☐ ☐ Weight gain
- ☐ ☐ Get sick a lot
- ☐ ☐ Swollen lymph nodes
- ☐ ☐ Hair loss

URINARY:

NOW PAST

- ☐ ☐ Hesitancy
- ☐ ☐ Frequent UTI
- ☐ ☐ Pain/burning
- ☐ ☐ Urgency
- ☐ ☐ Leaking

MALE REPRODUCTIVE:

NOW PAST

- ☐ ☐ Discharge from penis
- ☐ ☐ Ejaculation problem
- ☐ ☐ Genital pain
- ☐ ☐ Impotence
- ☐ ☐ Lumps in testicles
- ☐ ☐ Poor libido (sex drive)

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FEMALE REPRODUCTIVE:

NOW PAST

- ☐ ☐ Breast cysts
- ☐ ☐ Breast tenderness
- ☐ ☐ Ovarian cyst
- ☐ ☐ Poor libido (sex drive)
- ☐ ☐ Pelvic pain
- ☐ ☐ Infertility
- ☐ ☐ Vaginal discharge
- ☐ ☐ Vaginal itch
- ☐ ☐ Vaginal pain

PREMENSTRUAL:

NOW PAST

- ☐ ☐ Bloating
- ☐ ☐ Breast tenderness
- ☐ ☐ Food cravings
- ☐ ☐ Sleep change
- ☐ ☐ Fatigue
- ☐ ☐ Irritability

MENSTRUAL:

NOW PAST

- ☐ ☐ Cramps
- ☐ ☐ Heavy periods
- ☐ ☐ Irregular periods
- ☐ ☐ No periods
- ☐ ☐ Spotting

MENOPAUSE:

NOW PAST

- ☐ ☐ Hot flashes
- ☐ ☐ Mood Swings
- ☐ ☐ Concentration
- ☐ ☐ Memory
- ☐ ☐ Vaginal dryness
- ☐ ☐ Painful sex
- ☐ ☐ Decreased libido
- ☐ ☐ Weight gain
- ☐ ☐ Frequent urination

PAST AND CURRENT MEDICAL DIAGNOSES

Check box if you have been diagnosed with any of the conditions below, either presently or in the past (prior to 6 months)

GASTROINTESTINAL:

NOW PAST

- ☐ ☐ Irritable Bowel Syndrome
- ☐ ☐ Inflammatory Bowel Disease
- ☐ ☐ Crohn's disease
- ☐ ☐ Ulcerative Colitis
- ☐ ☐ Gastritis or Peptic Ulcer Disease
- ☐ ☐ GERD (reflux)
- ☐ ☐ Celiac Disease
- ☐ ☐ Other_____

CARDIOVASCULAR:

NOW PAST

- ☐ ☐ Heart Attack
- ☐ ☐ Stroke
- ☐ ☐ Elevated Cholesterol
- ☐ ☐ Arrythmia (irregular heart rate)
- ☐ ☐ High blood pressure
- ☐ ☐ Rheumatic Fever
- ☐ ☐ Other_____

METABOLIC/ENDOCRINE:

NOW PAST

- ☐ ☐ Type 1 Diabetes
- ☐ ☐ Type 2 Diabetes
- ☐ ☐ Hypoglycemia
- ☐ ☐ Metabolic Syndrome

METABOLIC/ENDOCRINE:

NOW PAST

- ☐ ☐ Insulin Resistance
- ☐ ☐ Hypothyroidism (low thyroid)
- ☐ ☐ Hyperthyroidism (overactive)
- ☐ ☐ Polycystic Ovarian Syndrome
- ☐ ☐ Bulimia
- ☐ ☐ Anorexia
- ☐ ☐ Binge Eating Disorder
- ☐ ☐ Eating Disorder (non-specific)
- ☐ ☐ Other_____

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CANCER:

NOW PAST

- ☐ ☐ Lung Cancer
- ☐ ☐ Breast Cancer
- ☐ ☐ Colon Cancer
- ☐ ☐ Ovarian Cancer
- ☐ ☐ Prostate Cancer
- ☐ ☐ Skin Cancer
- ☐ ☐ Other _____

GENITAL AND URINARY:

NOW PAST

- ☐ ☐ Kidney Stones
- ☐ ☐ Gout
- ☐ ☐ Interstitial Cystitis
- ☐ ☐ Frequent Urinary Tract Infections
- ☐ ☐ Frequent Yeast Infections
- ☐ ☐ Erectile Dysfunction
- ☐ ☐ or Sexual Dysfunction
- ☐ ☐ Other _____

MUSCULOSKELETAL OR PAIN

NOW PAST

- ☐ ☐ Osteoarthritis
- ☐ ☐ Fibromyalgia
- ☐ ☐ Chronic Pain
- ☐ ☐ Other _____

INFLAMMATORY/ AUTOIMMUNE:

NOW PAST

- ☐ ☐ Chronic Fatigue Syndrome
- ☐ ☐ Autoimmune Thyroid
- ☐ ☐ Hashimoto or Graves
- ☐ ☐ Rheumatoid Arthritis
- ☐ ☐ Lupus SLE
- ☐ ☐ Immune Deficiency Disease
- ☐ ☐ Severe Infectious Disease
- ☐ ☐ Food Allergies
- ☐ ☐ Environmental Allergies
- ☐ ☐ Multiple Chemical Sensitivities
- ☐ ☐ Lime Disease
- ☐ ☐ Latex Allergy
- ☐ ☐ Mono or Epstein Barr
- ☐ ☐ Other Autoimmune

_____

RESPIRATORY DISEASES:

NOW PAST

- ☐ ☐ Asthma
- ☐ ☐ Chronic Sinusitis
- ☐ ☐ Bronchitis
- ☐ ☐ Emphysema
- ☐ ☐ Pneumonia
- ☐ ☐ Tuberculosis
- ☐ ☐ Sleep Apnea
- ☐ ☐ Other _____

SKIN DISEASES:

NOW PAST

- ☐ ☐ Eczema
- ☐ ☐ Psoriasis
- ☐ ☐ Acne
- ☐ ☐ Melanoma
- ☐ ☐ Skin Cancer
- ☐ ☐ Other _____

NEUROLOGIC/MOOD:

NOW PAST

- ☐ ☐ Depression
- ☐ ☐ Anxiety
- ☐ ☐ Bipolar Disorder
- ☐ ☐ Schizophrenia
- ☐ ☐ Headaches
- ☐ ☐ Migraines
- ☐ ☐ ADD/ADHD
- ☐ ☐ Autism
- ☐ ☐ Mild Cognitive Impairment
- ☐ ☐ Parkinson's Disease
- ☐ ☐ Multiple Sclerosis
- ☐ ☐ Seizures
- ☐ ☐ Other Neurological Diagnosis

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MEDICATION AND ALLERGIES

CURRENT MEDICATIONS – USE A SEPARATE SHEET IF NECESSARY

MEDICATION	REASON FOR USE

ALLERGY INFORMATION

MEDICATION/SUPPLEMENT/FOOD	REACTION

Prolonged or regular use of NSAIDS (Advil, Aleve, etc.), Motrin, Aspirin, Tylenol

Prolonged use of acid Blocking Drugs (Tagamet, Zantac, Prilosec, etc.)

Use of steroids (Prednisone, inhalers) in the past

Prolonged use of Antibiotics

Prolonged use of Antidepressants

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PAST MEDICAL HISTORY

YOUR BIRTH HISTORY:

Term

Premature

Pregnancy or Birth Complications:

_____

_____

_____

_____

YOUR CHILDHOOD HISTORY

Check box if yes:

Lots of candy or sugar as a child

Ear infections

Recurrent strep throat

Lots of antibiotics

Stomach aches

Mono

Other childhood illness

_____

DENTAL HISTORY

Lots of cavities as a child

Silver Mercury Fillings

How many? _____

Gold Fillings

Root Canals

Implants

Tooth Pain

Bleeding Gums

Gingivitis

Floss regularly

INJURIES:

Back injury _____

Neck injury_____

Head injury _____

Broken bones_____

Other injury _____

FOR WOMEN:

OBSTETRIC HISTORY

Check box if yes and provide number of:

Pregnancies:_____

Caesarean:_____

Vaginal deliveries:_____

Miscarriage:_____

Abortion:_____

Living Children:_____

Post Partum Depression

Toxemia

Gestational Diabetes

Baby over 8 pounds

Breast Feeding

for how long?_____

MENSTRUAL HISTORY

Age at first period:_____

Menses Frequency:_____

Length:_____

Yes No

Pain

Clotting

Has your period ever skipped?_____

For how long?_____

Last Menstrual Period:_____

Use contraception

Birth Control Pills

Currently. # Years? _____

Past. When? _____

Patch

Nuva Ring

How long? _____

Condom

Diaphragm

IUD

Partner vasectomy

MENOPAUSE HISTORY

Menopause, Age of last period_____

Hormone replacement therapy

Currently? # Years? _____

Past: When? _____

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PAST SURGICAL HISTORY AND HOSPITALIZATIONS

DATE	CONDITION / REASON

PREVENTATIVE/DIAGNOSTIC TESTING

Check box if yes and provide date

Full Physical Exam _____

Bone Density _____

Colonoscopy _____

Cardiac Stress Test _____

EBT Heart Scan _____

EKG _____

Hemoccult Test-stool test for blood _____

MRI _____

CT Scan _____

Upper Endoscopy _____

Upper GI Series _____

Ultrasound _____

MEN'S PREVENTIVE TESTING

Check box if yes and provide the date

Last PSA_____

PSA Level: 0-2 2-4 4-10 > 10

Last Prostate exam (rectal)_____

Results _____

WOMEN'S PREVENTIVE TESTING

Check box if yes and provide the date

Last Mammogram:_____

Need a Biopsy? Date_____

PAP test date _____

Normal Abnormal

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ENVIRONMENTAL OR OTHER EXPOSURES AND DETOX ASSESSMENT

ADVERSE REACTION TO:

Caffeine:

Irritable Wired Aches & Pains

Monosodium glutamate (MSG)

Aspartame (Nutrasweet)

Bananas Garlic Onion Cheese

Citrus foods Chocolate Alcohol

Red Wine

Sulfite containing foods
(wine, dried fruit, salad bars)

Preservatives
(ex. sodium benzoate)

Other_____

YOU ARE EFFECTED BY:

Cigarette Smoke

Perfumes/Colognes

Auto Exhaust Fumes

Other: _____

IN YOUR WORK OR HOME ENVIRONMENT, ARE YOU EXPOSED TO:

Chemicals

Electromagnetic Radiation

Mold

HISTORY OF:

Jaundice (turning yellow)

Gilbert's syndrome or a liver disorder.

Explain_____

EXPOSURE TO HARMFUL CHEMICALS SUCH AS:

Herbicides

Insecticides (frequent visits of exterminator)

Pesticides

Organic Solvents

Heavy Metals

Other _____

Chemical Name, Date, Length of Exposure

_____

_____

_____

Dry clean your clothes frequently

Lived or worked in a damp or moldy environment or had other mold exposures

Do you have any pets or farm animals

_____

Work with oil based paint as artist or painter

History of drinking problem (see Lifestyle section for detailed questions)

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SOCIAL AND PERSONAL HISTORY

RELATIONSHIPS

Single Married Divorced Gay/Lesbian Long Term Partnership

List Children:

CHILD'S NAME	AGE	GENDER

Who is living in Household? Number_____

Names _____

Their Employment/Occupation: _____

Where do you find emotional support? Check all that apply:

Spouse Family Friends Religious/Spiritual Pets Other: _____

LIFESTYLE AND SELF-CARE

SMOKING

Currently Smoking

How many years? _____

Packs per day: _____

Attempts to quit:_____

_____

Previous Smoking:

How many years?_____

Packs per day?_____

2nd Hand smoke exposure

_____

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ALCOHOL INTAKE:

How many drinks currently per week?

1 drink = 5 ounces wine, 12 oz beer, 1.5 ounces spirits

None 1-3 4-6 7-10 > 10

PREVIOUS ALCOHOL INTAKE:

Mild Moderate High None

Been told you should cut down your alcohol intake

Feel guilty about your alcohol consumption

Have been unable to remember what you did during a drinking episode

Get into arguments or physical fights when you have been drinking

Been arrested or hospitalized because of drinking

Thought about getting help to control or stop your drinking

OTHER SUBSTANCES

Caffeine intake:

Cups/day:

Coffee 1 2-4 > 4 a day

Tea 1 2-4 > 4 a day

CAFFEINATED OR DIET SODAS INTAKE:

12-oz can/bottle/day 1 2-4 > 4 a day

List favorite type: Ex. Diet Coke, Pepsi:

_____

Recreational drugs

Type_____

EXERCISE, STRESS, AND SLEEP

EXERCISE - Current Exercise Program

ACTIVITY	TYPE	HOW OFTEN EACH WEEK	HOW LONG
Stretching			
Cardio / Aerobics			
Strength			
Other (Yoga, Pilates, etc.)			
Sports or Leisure Activity			

Rate your level of motivation for including exercise in your life? Low Medium High

List problems that limit activity: _____

Do you feel unusually fatigued after exercise? Yes No

If yes, please describe: _____

Do you usually sweat when exercising? Yes No

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STRESS/COPING

Check all that apply

I have been in counseling in the past

I am currently in therapy. Describe: _____

I have excessive amount of stress.

I have trouble handling the stress in my life

Daily Stressors: Rate on scale of 1-10 (10 is the worst)

Work _____ Family _____ Social _____ Finances _____ Health _____ Other _____

I practice meditation or a relaxation technique. How often? _____

Check all that apply:

Yoga Meditation Imagery Breathing Tai Chi Prayer Other: _____

SLEEP

Average number of hours you sleep per night: >10 8-10 6-8 < 6

What time do you go to sleep? _____ Wake up? _____

Trouble falling asleep

Still feel tired in the morning

Wake up during the night and can't fall back to sleep

Snoring is an issue. You or your partner? _____

Rely on sleeping pills

NUTRITION AND DIET

NUTRITION HISTORY

Have you ever had a nutrition consultation? Yes No

Have you made any changes in your eating habits because of your health? Yes No

Describe _____

Do you currently follow a special diet or nutritional program? Yes No

CHECK ALL THAT APPLY:

Low Fat Low Carbohydrate High Protein Low Sodium Diabetic No Dairy No Wheat
Gluten Restricted Vegetarian Vegan

Specific Program for Weight Loss/Maintenance Type: _____

Other_____

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NUTRITION AND DIET

How often do you weigh yourself? Daily Weekly Monthly Rarely Never

Do you avoid any particular foods? Yes No
If yes, types and reason _____

If you could only eat a few foods a week, what would they be? _____
_____

Do you grocery shop? Yes No If no, who does the shopping? _____

Do you read food labels? Yes No _____

Do you cook? Yes No If no, who does the cooking? _____

How many meals do you eat out per week? 0-1 1-3 3-5 >5 meals per week

Check all the factors that apply to your current lifestyle and eating habits:

Fast eater
Erratic eating pattern
Eat too much
Late night eating
Dislike healthy food
Time constraints
Eat more than _____% meals away from home
Travel frequently
Non-availability of healthy foods
Do not plan meals or menus
Reliance on convenience items
Poor snack choices
Significant other or family members don't like healthy foods
Significant other or family members have special dietary needs or food preferences
Love to eat
Eat because I have to
Have a negative relationship to food
Struggle with eating issues
Emotional eater (eat when sad, lonely, depressed, bored)
Eat too much under stress
Eat too little under stress
Don't care to cook
Eating in the middle of the night
Confused about nutrition advice

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THE MOST IMPORTANT THING I SHOULD CHANGE ABOUT MY DIET TO IMPROVE MY HEALTH IS:

_____

Height (feet/inches)_____ Current Weight _____

Usual Weight Range +/- 5 lbs _____ Desired Weight Range +/- 5 lbs _____

Highest adult weight _____ Lowest adult weight _____

Weight Fluctuations (> 10 lbs.) Yes No Body Fat % _____

NUTRITIONAL SUPPLEMENTS (VITAMINS,HERBS, HOMEOPATHY)

SUPPLEMENT/BRAND	REASON FOR USE

READINESS TO CHANGE

RATE ON A SCALE OF: 5 (VERY WILLING) TO 1 (NOT WILLING).

In order to improve your health, how willing are you to:

Significantly modify your diet:
5 ◯ 4 ◯ 3 ◯ 2 ◯ 1 ◯

Modify your lifestyle (e.g.,work demands, sleep habits)
5 ◯ 4 ◯ 3 ◯ 2 ◯ 1 ◯

Take several nutritional supplements each day
5 ◯ 4 ◯ 3 ◯ 2 ◯ 1 ◯

Practice a relaxation technique
5 ◯ 4 ◯ 3 ◯ 2 ◯ 1 ◯

Keep a record of everything you eat each day
5 ◯ 4 ◯ 3 ◯ 2 ◯ 1 ◯

Engage in regular exercise
5 ◯ 4 ◯ 3 ◯ 2 ◯ 1 ◯

Comments _____

How confident are you of your ability to organize and follow through on the above health related activities?
5 ◯ 4 ◯ 3 ◯ 2 ◯ 1 ◯

At the present time, how supportive do you think the people in your household will be to your implementing the above changes? 5 ◯ 4 ◯ 3 ◯ 2 ◯ 1 ◯

Comments _____

3 DAY FOOD INTAKE DIARY INSTRUCTIONS:

It is important to keep an accurate record of your food and beverage intake as a part of your treatment plan. Please complete this Food Intake Diary for 3 consecutive days including one weekend day.

- List all foods and drinks, including the amount of each.
- Describe the food or beverage as accurately as possible e.g., milk - what kind? (whole, 2%, nonfat); toast - (whole wheat, white, buttered); chicken - (fried, baked, breaded), coffee – (decaffeinated with sugar and 1⁄2 & 1⁄2).
- Make note as to whether the food was fresh, frozen, canned, raw, cooked, baked, fried, etc.
- Be sure to include condiments (mustard, mayonnaise, relish, pickles, etc.).
- Record water intake.
- Record any symptoms that you felt throughout the day (fatigue, anxious, gas, bloating, nausea).
- Record the amount of each food or beverage consumed using standard measurements such as 8 ounces, 1/2 cup, 1 teaspoon, etc.
- Please note all bowel movements and their consistency (regular, loose, firm, etc.)
- Record any exercise you do each day, including the type of activity and its duration.

DAY 1

TIME	FOOD/BEVERAGE	AMOUNT

Bowel Movements (at what time of the day, #, form, color):

_____

Exercise (time spent, type of exercise):

_____

Symptoms (at what time of the day, describe symptom):

_____

Other comments:_____

DAY 2

TIME	FOOD/BEVERAGE AMOUNT	COMMENT

Bowel Movements (#, form, color):

_____

Exercise:

_____

Symptoms:

_____

Other comments:_____

DAY 3

TIME	FOOD/BEVERAGE AMOUNT	COMMENT

Bowel Movements (#, form, color):

_____

Exercise:

_____

Symptoms:

_____

Other comments:_____