



DATE	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	
<b>PHYSICAL ILLNESS</b> <i>(What did you have?)</i>																																
<i>notes</i>																																
<b>MENSTRUAL PERIOD</b> <i>(What type of flow?)</i>																																
<i>notes</i>																																
<b>MEALS</b> <i>(How many daily meals?)</i>																																
<i>notes</i>																																
<b>SNACKS</b> <i>(How many?)</i>																																
<i>notes</i>																																
<b>WEIGHT CHANGES</b> <i>(indicate + or -)</i>																																
<i>notes</i>																																
<b>ALCOHOL USE</b>																																
<i>notes</i>																																
<b>DRUG USE</b>																																
<i>notes</i>																																
<b>JOBS</b> <i>(Days at work)</i>																																
<i>notes</i>																																
<b>PHYSICAL ACTIVITY/EXERCISE</b>																																
<i>notes</i>																																
<b>RELAXATION/MEDITATION</b>																																
<i>notes</i>																																