Patient Name: _____ *Date started:* _____

5 Day Diet Diary *Quantum Light Healthcare.com* *Dr. Kat Halloran, ND* *206-601-2612*

Instructions: Please log 3 weekdays and 2 weekend days of all food, water, beverages, snacks, medication, supplements and vitamin intake. Also notice how you feel after you eat. Do you feel heavy, groggy, tired, brain fog, headache, migraine, stomach pain, gas, heartburn, itchy, nasal congestion, sneezy, rashes, cranky, irritable, unable to sleep at night or other symptoms. Note your stress level throughout the day and your emotions. Note bowel and urine habits, comment on constipation or diarrhea. Notate if you skip meals, list your meal times and the dates. Bring this with you to our next appt or fax (425-888-0636) it to me if we are consulting by telephone. Print out or electronically fill in as many pages as you need to document 5 days of nutrition.

Date and Time of each meal:	Food / Water / Vitamins / Drinks	Any noticeable reactions?	Bowel and Urine Habits	Emotions

Date and Time of each meal:	Food / Water / Vitamins / Drinks	Any noticeable reactions?	Bowel and Urine Habits	Emotions