

Food & Vitality Log

Gut Health & Somatic Healing | A 7-day tracking log

Why keep a log?

Many people live with digestive, energy, sleep, or mood symptoms for so long that those symptoms feel normal. A simple log helps you and your care team see patterns over time: which foods, times, sleep habits, or stressors line up with feeling unsettled, and which line up with feeling steady and well. Approach it with curiosity, not judgment.

How to use it

- Type directly into the boxes on a phone, tablet, or computer, or print the pages and write by hand.
- Each day has two pages: Page A for meals and snacks, Page B for bowel movements, sleep, energy, habits, and food trials.
- Fill in meals soon after eating. Note when symptoms start, since some reactions show up hours later.
- Track for 1 to 2 weeks at first. Save a new copy of this file each week (for example, Log-Week-1.pdf).
- Use the Weekly Review page to count different plant foods and note patterns.
- Bring the log to appointments with your doctor, registered dietitian, or counselor. Your providers interpret the patterns with you.

A gentle caution

Detailed food tracking is not right for everyone. If you have a history of eating concerns, or if tracking starts to feel stressful or controlling, skip the amounts and track only symptoms and experiences, or use this log only with guidance from your provider.

Get emergency help right away (call 911; use epinephrine if prescribed) if after eating you have:

trouble breathing or wheezing, throat tightness, swelling of the tongue or lips, trouble swallowing, feeling faint, widespread hives, or repeated vomiting. Also seek prompt medical care for chest pain, fainting, new or persistent heart racing or skipped beats, blood in the stool, unexplained weight loss, or severe abdominal pain.

Name (optional)

Week starting

This log is for informational and educational purposes only. It is not medical advice, diagnosis, or treatment, and it does not replace care from your medical providers. Always talk with your physician and pharmacist before changing your diet, supplements, or medications.

Prepared by Dr. Darleen Claire Wodzinski, MS ESE, MA CMHC, PhD, LPC, NCC, ACS, Clinical Director, Orchard Human Services, Inc. | orchardhumanservices.org

Day 1 | Page A: Meals and snacks

Log what you eat and drink, how much, and how your body responds.

Date

Overall, today my gut felt (0 = settled, 10 = very unsettled)

Meal / snack 1

Time What I ate / drank

Amount Hunger before (0-10) Fullness after (0-10) Symptoms began at

Check any symptoms within 24 hours:

- | | | | |
|--|---|--|--|
| ☐ Bloating | ☐ Gas | ☐ Cramping/pain | ☐ Reflux |
| ☐ Nausea | ☐ Diarrhea | ☐ Constipation | ☐ Headache |
| ☐ Head pressure | ☐ Brain fog | ☐ Fatigue/sleepy | ☐ Edgy/irritable |
| ☐ Racing/skipped beat | ☐ Itch/flush/hives | ☐ Mouth/throat itch | ☐ Dizzy on standing |

What I noticed

Meal / snack 2

Time What I ate / drank

Amount Hunger before (0-10) Fullness after (0-10) Symptoms began at

Check any symptoms within 24 hours:

- | | | | |
|--|---|--|--|
| ☐ Bloating | ☐ Gas | ☐ Cramping/pain | ☐ Reflux |
| ☐ Nausea | ☐ Diarrhea | ☐ Constipation | ☐ Headache |
| ☐ Head pressure | ☐ Brain fog | ☐ Fatigue/sleepy | ☐ Edgy/irritable |
| ☐ Racing/skipped beat | ☐ Itch/flush/hives | ☐ Mouth/throat itch | ☐ Dizzy on standing |

What I noticed

Meal / snack 3

Time What I ate / drank

Amount Hunger before (0-10) Fullness after (0-10) Symptoms began at

Check any symptoms within 24 hours:

- | | | | |
|--|---|--|--|
| ☐ Bloating | ☐ Gas | ☐ Cramping/pain | ☐ Reflux |
| ☐ Nausea | ☐ Diarrhea | ☐ Constipation | ☐ Headache |
| ☐ Head pressure | ☐ Brain fog | ☐ Fatigue/sleepy | ☐ Edgy/irritable |
| ☐ Racing/skipped beat | ☐ Itch/flush/hives | ☐ Mouth/throat itch | ☐ Dizzy on standing |

What I noticed

Meal / snack 4

Time What I ate / drank

Amount Hunger before (0-10) Fullness after (0-10) Symptoms began at

Check any symptoms within 24 hours:

- | | | | |
|--|---|--|--|
| ☐ Bloating | ☐ Gas | ☐ Cramping/pain | ☐ Reflux |
| ☐ Nausea | ☐ Diarrhea | ☐ Constipation | ☐ Headache |
| ☐ Head pressure | ☐ Brain fog | ☐ Fatigue/sleepy | ☐ Edgy/irritable |
| ☐ Racing/skipped beat | ☐ Itch/flush/hives | ☐ Mouth/throat itch | ☐ Dizzy on standing |

What I noticed

Day 1 | Page B: Body, sleep, and energy

Bowel movements, vitality ratings, daily habits, and food trials.

Bowel movements (Bristol Stool Scale)

Number today Check every type you had:

- ☐ 1 Separate hard lumps
- ☐ 2 Lumpy, sausage-shaped
- ☐ 3 Sausage with cracks
- ☐ 4 Smooth, soft sausage
- ☐ 5 Soft blobs, clear edges
- ☐ 6 Mushy, ragged pieces
- ☐ 7 Watery, no solid pieces

Types 3-4 are generally considered typical. Types 1-2 suggest constipation; 6-7 suggest loose stools.

Vitality ratings (0-10)

Energy Mood Stress Calm / settled body

Sleep

Bedtime Wake time Hours slept Sleep quality (0-10) Night wakings

Woke between 2 and 4 AM with racing heart, sweating, or vivid dreams? ☐ Yes - note for your provider

Daily habits

Water (cups) Morning outdoor light (min) Screens off at Movement (min)

☐ Ultra-processed foods avoided today ☐ Breathing, humming, or calming practice ☐ Walk after a meal

Supplements and medications taken (name and time)

Food reintroduction trial (one food at a time, with your provider's guidance)

Food tested		Amount		Time	
After 24 hours					
After 48 hours					
After 72 hours					

Notes, experiences, and moments I felt well

Day 2 | Page A: Meals and snacks

Log what you eat and drink, how much, and how your body responds.

Date

Overall, today my gut felt (0 = settled, 10 = very unsettled)

Meal / snack 1

Time What I ate / drank

Amount Hunger before (0-10) Fullness after (0-10) Symptoms began at

Check any symptoms within 24 hours:

- | | | | |
|--|---|--|--|
| ☐ Bloating | ☐ Gas | ☐ Cramping/pain | ☐ Reflux |
| ☐ Nausea | ☐ Diarrhea | ☐ Constipation | ☐ Headache |
| ☐ Head pressure | ☐ Brain fog | ☐ Fatigue/sleepy | ☐ Edgy/irritable |
| ☐ Racing/skipped beat | ☐ Itch/flush/hives | ☐ Mouth/throat itch | ☐ Dizzy on standing |

What I noticed

Meal / snack 2

Time What I ate / drank

Amount Hunger before (0-10) Fullness after (0-10) Symptoms began at

Check any symptoms within 24 hours:

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|--|---|--|--|
| ☐ Bloating | ☐ Gas | ☐ Cramping/pain | ☐ Reflux |
| ☐ Nausea | ☐ Diarrhea | ☐ Constipation | ☐ Headache |
| ☐ Head pressure | ☐ Brain fog | ☐ Fatigue/sleepy | ☐ Edgy/irritable |
| ☐ Racing/skipped beat | ☐ Itch/flush/hives | ☐ Mouth/throat itch | ☐ Dizzy on standing |

What I noticed

Meal / snack 3

Time What I ate / drank

Amount Hunger before (0-10) Fullness after (0-10) Symptoms began at

Check any symptoms within 24 hours:

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| ☐ Bloating | ☐ Gas | ☐ Cramping/pain | ☐ Reflux |
| ☐ Nausea | ☐ Diarrhea | ☐ Constipation | ☐ Headache |
| ☐ Head pressure | ☐ Brain fog | ☐ Fatigue/sleepy | ☐ Edgy/irritable |
| ☐ Racing/skipped beat | ☐ Itch/flush/hives | ☐ Mouth/throat itch | ☐ Dizzy on standing |

What I noticed

Meal / snack 4

Time What I ate / drank

Amount Hunger before (0-10) Fullness after (0-10) Symptoms began at

Check any symptoms within 24 hours:

- | | | | |
|--|---|--|--|
| ☐ Bloating | ☐ Gas | ☐ Cramping/pain | ☐ Reflux |
| ☐ Nausea | ☐ Diarrhea | ☐ Constipation | ☐ Headache |
| ☐ Head pressure | ☐ Brain fog | ☐ Fatigue/sleepy | ☐ Edgy/irritable |
| ☐ Racing/skipped beat | ☐ Itch/flush/hives | ☐ Mouth/throat itch | ☐ Dizzy on standing |

What I noticed

Day 2 | Page B: Body, sleep, and energy

Bowel movements, vitality ratings, daily habits, and food trials.

Bowel movements (Bristol Stool Scale)

Number today

Check every type you had:

☐ 1 Separate hard lumps

☐ 2 Lumpy, sausage-shaped

☐ 3 Sausage with cracks

☐ 4 Smooth, soft sausage

☐ 5 Soft blobs, clear edges

☐ 6 Mushy, ragged pieces

☐ 7 Watery, no solid pieces

Types 3-4 are generally considered typical. Types 1-2 suggest constipation; 6-7 suggest loose stools.

Vitality ratings (0-10)

Energy

Mood

Stress

Calm / settled body

Sleep

Bedtime

Wake time

Hours slept

Sleep quality (0-10)

Night wakings

Woke between 2 and 4 AM with racing heart, sweating, or vivid dreams?

☐ Yes - note for your provider

Daily habits

Water (cups)

Morning outdoor light (min)

Screens off at

Movement (min)

☐ Ultra-processed foods avoided today

☐ Breathing, humming, or calming practice

☐ Walk after a meal

Supplements and medications taken (name and time)

Food reintroduction trial (one food at a time, with your provider's guidance)

Food tested

Amount

Time

After 24 hours

After 48 hours

After 72 hours

Notes, experiences, and moments I felt well

Day 3 | Page A: Meals and snacks

Log what you eat and drink, how much, and how your body responds.

Date

Overall, today my gut felt (0 = settled, 10 = very unsettled)

Meal / snack 1

Time What I ate / drank

Amount Hunger before (0-10) Fullness after (0-10) Symptoms began at

Check any symptoms within 24 hours:

- | | | | |
|--|---|--|--|
| ☐ Bloating | ☐ Gas | ☐ Cramping/pain | ☐ Reflux |
| ☐ Nausea | ☐ Diarrhea | ☐ Constipation | ☐ Headache |
| ☐ Head pressure | ☐ Brain fog | ☐ Fatigue/sleepy | ☐ Edgy/irritable |
| ☐ Racing/skipped beat | ☐ Itch/flush/hives | ☐ Mouth/throat itch | ☐ Dizzy on standing |

What I noticed

Meal / snack 2

Time What I ate / drank

Amount Hunger before (0-10) Fullness after (0-10) Symptoms began at

Check any symptoms within 24 hours:

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|--|---|--|--|
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| ☐ Nausea | ☐ Diarrhea | ☐ Constipation | ☐ Headache |
| ☐ Head pressure | ☐ Brain fog | ☐ Fatigue/sleepy | ☐ Edgy/irritable |
| ☐ Racing/skipped beat | ☐ Itch/flush/hives | ☐ Mouth/throat itch | ☐ Dizzy on standing |

What I noticed

Meal / snack 3

Time What I ate / drank

Amount Hunger before (0-10) Fullness after (0-10) Symptoms began at

Check any symptoms within 24 hours:

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|--|---|--|--|
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| ☐ Nausea | ☐ Diarrhea | ☐ Constipation | ☐ Headache |
| ☐ Head pressure | ☐ Brain fog | ☐ Fatigue/sleepy | ☐ Edgy/irritable |
| ☐ Racing/skipped beat | ☐ Itch/flush/hives | ☐ Mouth/throat itch | ☐ Dizzy on standing |

What I noticed

Meal / snack 4

Time What I ate / drank

Amount Hunger before (0-10) Fullness after (0-10) Symptoms began at

Check any symptoms within 24 hours:

- | | | | |
|--|---|--|--|
| ☐ Bloating | ☐ Gas | ☐ Cramping/pain | ☐ Reflux |
| ☐ Nausea | ☐ Diarrhea | ☐ Constipation | ☐ Headache |
| ☐ Head pressure | ☐ Brain fog | ☐ Fatigue/sleepy | ☐ Edgy/irritable |
| ☐ Racing/skipped beat | ☐ Itch/flush/hives | ☐ Mouth/throat itch | ☐ Dizzy on standing |

What I noticed

Day 3 | Page B: Body, sleep, and energy

Bowel movements, vitality ratings, daily habits, and food trials.

Bowel movements (Bristol Stool Scale)

Number today Check every type you had:

- ☐ 1 Separate hard lumps ☐ 2 Lumpy, sausage-shaped ☐ 3 Sausage with cracks ☐ 4 Smooth, soft sausage
☐ 5 Soft blobs, clear edges ☐ 6 Mushy, ragged pieces ☐ 7 Watery, no solid pieces

Types 3-4 are generally considered typical. Types 1-2 suggest constipation; 6-7 suggest loose stools.

Vitality ratings (0-10)

Energy Mood Stress Calm / settled body

Sleep

Bedtime Wake time Hours slept Sleep quality (0-10) Night wakings

Woke between 2 and 4 AM with racing heart, sweating, or vivid dreams? ☐ Yes - note for your provider

Daily habits

Water (cups) Morning outdoor light (min) Screens off at Movement (min)

☐ Ultra-processed foods avoided today ☐ Breathing, humming, or calming practice ☐ Walk after a meal

Supplements and medications taken (name and time)

Food reintroduction trial (one food at a time, with your provider's guidance)

Food tested Amount Time

After 24 hours

After 48 hours

After 72 hours

Notes, experiences, and moments I felt well

Day 4 | Page A: Meals and snacks

Log what you eat and drink, how much, and how your body responds.

Date

Overall, today my gut felt (0 = settled, 10 = very unsettled)

Meal / snack 1

Time What I ate / drank

Amount Hunger before (0-10) Fullness after (0-10) Symptoms began at

Check any symptoms within 24 hours:

- | | | | |
|--|---|--|--|
| ☐ Bloating | ☐ Gas | ☐ Cramping/pain | ☐ Reflux |
| ☐ Nausea | ☐ Diarrhea | ☐ Constipation | ☐ Headache |
| ☐ Head pressure | ☐ Brain fog | ☐ Fatigue/sleepy | ☐ Edgy/irritable |
| ☐ Racing/skipped beat | ☐ Itch/flush/hives | ☐ Mouth/throat itch | ☐ Dizzy on standing |

What I noticed

Meal / snack 2

Time What I ate / drank

Amount Hunger before (0-10) Fullness after (0-10) Symptoms began at

Check any symptoms within 24 hours:

- | | | | |
|--|---|--|--|
| ☐ Bloating | ☐ Gas | ☐ Cramping/pain | ☐ Reflux |
| ☐ Nausea | ☐ Diarrhea | ☐ Constipation | ☐ Headache |
| ☐ Head pressure | ☐ Brain fog | ☐ Fatigue/sleepy | ☐ Edgy/irritable |
| ☐ Racing/skipped beat | ☐ Itch/flush/hives | ☐ Mouth/throat itch | ☐ Dizzy on standing |

What I noticed

Meal / snack 3

Time What I ate / drank

Amount Hunger before (0-10) Fullness after (0-10) Symptoms began at

Check any symptoms within 24 hours:

- | | | | |
|--|---|--|--|
| ☐ Bloating | ☐ Gas | ☐ Cramping/pain | ☐ Reflux |
| ☐ Nausea | ☐ Diarrhea | ☐ Constipation | ☐ Headache |
| ☐ Head pressure | ☐ Brain fog | ☐ Fatigue/sleepy | ☐ Edgy/irritable |
| ☐ Racing/skipped beat | ☐ Itch/flush/hives | ☐ Mouth/throat itch | ☐ Dizzy on standing |

What I noticed

Meal / snack 4

Time What I ate / drank

Amount Hunger before (0-10) Fullness after (0-10) Symptoms began at

Check any symptoms within 24 hours:

- | | | | |
|--|---|--|--|
| ☐ Bloating | ☐ Gas | ☐ Cramping/pain | ☐ Reflux |
| ☐ Nausea | ☐ Diarrhea | ☐ Constipation | ☐ Headache |
| ☐ Head pressure | ☐ Brain fog | ☐ Fatigue/sleepy | ☐ Edgy/irritable |
| ☐ Racing/skipped beat | ☐ Itch/flush/hives | ☐ Mouth/throat itch | ☐ Dizzy on standing |

What I noticed

Day 4 | Page B: Body, sleep, and energy

Bowel movements, vitality ratings, daily habits, and food trials.

Bowel movements (Bristol Stool Scale)

Number today Check every type you had:

- ☐ 1 Separate hard lumps
- ☐ 2 Lumpy, sausage-shaped
- ☐ 3 Sausage with cracks
- ☐ 4 Smooth, soft sausage
- ☐ 5 Soft blobs, clear edges
- ☐ 6 Mushy, ragged pieces
- ☐ 7 Watery, no solid pieces

Types 3-4 are generally considered typical. Types 1-2 suggest constipation; 6-7 suggest loose stools.

Vitality ratings (0-10)

Energy Mood Stress Calm / settled body

Sleep

Bedtime Wake time Hours slept Sleep quality (0-10) Night wakings

Woke between 2 and 4 AM with racing heart, sweating, or vivid dreams? ☐ Yes - note for your provider

Daily habits

Water (cups) Morning outdoor light (min) Screens off at Movement (min)
☐ Ultra-processed foods avoided today ☐ Breathing, humming, or calming practice ☐ Walk after a meal

Supplements and medications taken (name and time)

Food reintroduction trial (one food at a time, with your provider's guidance)

Food tested		Amount		Time	
After 24 hours					
After 48 hours					
After 72 hours					

Notes, experiences, and moments I felt well

Day 5 | Page A: Meals and snacks

Log what you eat and drink, how much, and how your body responds.

Date

Overall, today my gut felt (0 = settled, 10 = very unsettled)

Meal / snack 1

Time What I ate / drank

Amount Hunger before (0-10) Fullness after (0-10) Symptoms began at

Check any symptoms within 24 hours:

- | | | | |
|--|---|--|--|
| ☐ Bloating | ☐ Gas | ☐ Cramping/pain | ☐ Reflux |
| ☐ Nausea | ☐ Diarrhea | ☐ Constipation | ☐ Headache |
| ☐ Head pressure | ☐ Brain fog | ☐ Fatigue/sleepy | ☐ Edgy/irritable |
| ☐ Racing/skipped beat | ☐ Itch/flush/hives | ☐ Mouth/throat itch | ☐ Dizzy on standing |

What I noticed

Meal / snack 2

Time What I ate / drank

Amount Hunger before (0-10) Fullness after (0-10) Symptoms began at

Check any symptoms within 24 hours:

- | | | | |
|--|---|--|--|
| ☐ Bloating | ☐ Gas | ☐ Cramping/pain | ☐ Reflux |
| ☐ Nausea | ☐ Diarrhea | ☐ Constipation | ☐ Headache |
| ☐ Head pressure | ☐ Brain fog | ☐ Fatigue/sleepy | ☐ Edgy/irritable |
| ☐ Racing/skipped beat | ☐ Itch/flush/hives | ☐ Mouth/throat itch | ☐ Dizzy on standing |

What I noticed

Meal / snack 3

Time What I ate / drank

Amount Hunger before (0-10) Fullness after (0-10) Symptoms began at

Check any symptoms within 24 hours:

- | | | | |
|--|---|--|--|
| ☐ Bloating | ☐ Gas | ☐ Cramping/pain | ☐ Reflux |
| ☐ Nausea | ☐ Diarrhea | ☐ Constipation | ☐ Headache |
| ☐ Head pressure | ☐ Brain fog | ☐ Fatigue/sleepy | ☐ Edgy/irritable |
| ☐ Racing/skipped beat | ☐ Itch/flush/hives | ☐ Mouth/throat itch | ☐ Dizzy on standing |

What I noticed

Meal / snack 4

Time What I ate / drank

Amount Hunger before (0-10) Fullness after (0-10) Symptoms began at

Check any symptoms within 24 hours:

- | | | | |
|--|---|--|--|
| ☐ Bloating | ☐ Gas | ☐ Cramping/pain | ☐ Reflux |
| ☐ Nausea | ☐ Diarrhea | ☐ Constipation | ☐ Headache |
| ☐ Head pressure | ☐ Brain fog | ☐ Fatigue/sleepy | ☐ Edgy/irritable |
| ☐ Racing/skipped beat | ☐ Itch/flush/hives | ☐ Mouth/throat itch | ☐ Dizzy on standing |

What I noticed

Day 5 | Page B: Body, sleep, and energy

Bowel movements, vitality ratings, daily habits, and food trials.

Bowel movements (Bristol Stool Scale)

Number today

Check every type you had:

☐ 1 Separate hard lumps

☐ 2 Lumpy, sausage-shaped

☐ 3 Sausage with cracks

☐ 4 Smooth, soft sausage

☐ 5 Soft blobs, clear edges

☐ 6 Mushy, ragged pieces

☐ 7 Watery, no solid pieces

Types 3-4 are generally considered typical. Types 1-2 suggest constipation; 6-7 suggest loose stools.

Vitality ratings (0-10)

Energy

Mood

Stress

Calm / settled body

Sleep

Bedtime

Wake time

Hours slept

Sleep quality (0-10)

Night wakings

Woke between 2 and 4 AM with racing heart, sweating, or vivid dreams?

☐ Yes - note for your provider

Daily habits

Water (cups)

Morning outdoor light (min)

Screens off at

Movement (min)

☐ Ultra-processed foods avoided today

☐ Breathing, humming, or calming practice

☐ Walk after a meal

Supplements and medications taken (name and time)

Food reintroduction trial (one food at a time, with your provider's guidance)

Food tested

Amount

Time

After 24 hours

After 48 hours

After 72 hours

Notes, experiences, and moments I felt well

Day 6 | Page A: Meals and snacks

Log what you eat and drink, how much, and how your body responds.

Date

Overall, today my gut felt (0 = settled, 10 = very unsettled)

Meal / snack 1

Time What I ate / drank

Amount Hunger before (0-10) Fullness after (0-10) Symptoms began at

Check any symptoms within 24 hours:

- | | | | |
|--|---|--|--|
| ☐ Bloating | ☐ Gas | ☐ Cramping/pain | ☐ Reflux |
| ☐ Nausea | ☐ Diarrhea | ☐ Constipation | ☐ Headache |
| ☐ Head pressure | ☐ Brain fog | ☐ Fatigue/sleepy | ☐ Edgy/irritable |
| ☐ Racing/skipped beat | ☐ Itch/flush/hives | ☐ Mouth/throat itch | ☐ Dizzy on standing |

What I noticed

Meal / snack 2

Time What I ate / drank

Amount Hunger before (0-10) Fullness after (0-10) Symptoms began at

Check any symptoms within 24 hours:

- | | | | |
|--|---|--|--|
| ☐ Bloating | ☐ Gas | ☐ Cramping/pain | ☐ Reflux |
| ☐ Nausea | ☐ Diarrhea | ☐ Constipation | ☐ Headache |
| ☐ Head pressure | ☐ Brain fog | ☐ Fatigue/sleepy | ☐ Edgy/irritable |
| ☐ Racing/skipped beat | ☐ Itch/flush/hives | ☐ Mouth/throat itch | ☐ Dizzy on standing |

What I noticed

Meal / snack 3

Time What I ate / drank

Amount Hunger before (0-10) Fullness after (0-10) Symptoms began at

Check any symptoms within 24 hours:

- | | | | |
|--|---|--|--|
| ☐ Bloating | ☐ Gas | ☐ Cramping/pain | ☐ Reflux |
| ☐ Nausea | ☐ Diarrhea | ☐ Constipation | ☐ Headache |
| ☐ Head pressure | ☐ Brain fog | ☐ Fatigue/sleepy | ☐ Edgy/irritable |
| ☐ Racing/skipped beat | ☐ Itch/flush/hives | ☐ Mouth/throat itch | ☐ Dizzy on standing |

What I noticed

Meal / snack 4

Time What I ate / drank

Amount Hunger before (0-10) Fullness after (0-10) Symptoms began at

Check any symptoms within 24 hours:

- | | | | |
|--|---|--|--|
| ☐ Bloating | ☐ Gas | ☐ Cramping/pain | ☐ Reflux |
| ☐ Nausea | ☐ Diarrhea | ☐ Constipation | ☐ Headache |
| ☐ Head pressure | ☐ Brain fog | ☐ Fatigue/sleepy | ☐ Edgy/irritable |
| ☐ Racing/skipped beat | ☐ Itch/flush/hives | ☐ Mouth/throat itch | ☐ Dizzy on standing |

What I noticed

Day 6 | Page B: Body, sleep, and energy

Bowel movements, vitality ratings, daily habits, and food trials.

Bowel movements (Bristol Stool Scale)

Number today

Check every type you had:

☐ 1 Separate hard lumps

☐ 2 Lumpy, sausage-shaped

☐ 3 Sausage with cracks

☐ 4 Smooth, soft sausage

☐ 5 Soft blobs, clear edges

☐ 6 Mushy, ragged pieces

☐ 7 Watery, no solid pieces

Types 3-4 are generally considered typical. Types 1-2 suggest constipation; 6-7 suggest loose stools.

Vitality ratings (0-10)

Energy

Mood

Stress

Calm / settled body

Sleep

Bedtime

Wake time

Hours slept

Sleep quality (0-10)

Night wakings

Woke between 2 and 4 AM with racing heart, sweating, or vivid dreams?

☐ Yes - note for your provider

Daily habits

Water (cups)

Morning outdoor light (min)

Screens off at

Movement (min)

☐ Ultra-processed foods avoided today

☐ Breathing, humming, or calming practice

☐ Walk after a meal

Supplements and medications taken (name and time)

Food reintroduction trial (one food at a time, with your provider's guidance)

Food tested

Amount

Time

After 24 hours

After 48 hours

After 72 hours

Notes, experiences, and moments I felt well

Day 7 | Page A: Meals and snacks

Log what you eat and drink, how much, and how your body responds.

Date

Overall, today my gut felt (0 = settled, 10 = very unsettled)

Meal / snack 1

Time What I ate / drank

Amount Hunger before (0-10) Fullness after (0-10) Symptoms began at

Check any symptoms within 24 hours:

- | | | | |
|--|---|--|--|
| ☐ Bloating | ☐ Gas | ☐ Cramping/pain | ☐ Reflux |
| ☐ Nausea | ☐ Diarrhea | ☐ Constipation | ☐ Headache |
| ☐ Head pressure | ☐ Brain fog | ☐ Fatigue/sleepy | ☐ Edgy/irritable |
| ☐ Racing/skipped beat | ☐ Itch/flush/hives | ☐ Mouth/throat itch | ☐ Dizzy on standing |

What I noticed

Meal / snack 2

Time What I ate / drank

Amount Hunger before (0-10) Fullness after (0-10) Symptoms began at

Check any symptoms within 24 hours:

- | | | | |
|--|---|--|--|
| ☐ Bloating | ☐ Gas | ☐ Cramping/pain | ☐ Reflux |
| ☐ Nausea | ☐ Diarrhea | ☐ Constipation | ☐ Headache |
| ☐ Head pressure | ☐ Brain fog | ☐ Fatigue/sleepy | ☐ Edgy/irritable |
| ☐ Racing/skipped beat | ☐ Itch/flush/hives | ☐ Mouth/throat itch | ☐ Dizzy on standing |

What I noticed

Meal / snack 3

Time What I ate / drank

Amount Hunger before (0-10) Fullness after (0-10) Symptoms began at

Check any symptoms within 24 hours:

- | | | | |
|--|---|--|--|
| ☐ Bloating | ☐ Gas | ☐ Cramping/pain | ☐ Reflux |
| ☐ Nausea | ☐ Diarrhea | ☐ Constipation | ☐ Headache |
| ☐ Head pressure | ☐ Brain fog | ☐ Fatigue/sleepy | ☐ Edgy/irritable |
| ☐ Racing/skipped beat | ☐ Itch/flush/hives | ☐ Mouth/throat itch | ☐ Dizzy on standing |

What I noticed

Meal / snack 4

Time What I ate / drank

Amount Hunger before (0-10) Fullness after (0-10) Symptoms began at

Check any symptoms within 24 hours:

- | | | | |
|--|---|--|--|
| ☐ Bloating | ☐ Gas | ☐ Cramping/pain | ☐ Reflux |
| ☐ Nausea | ☐ Diarrhea | ☐ Constipation | ☐ Headache |
| ☐ Head pressure | ☐ Brain fog | ☐ Fatigue/sleepy | ☐ Edgy/irritable |
| ☐ Racing/skipped beat | ☐ Itch/flush/hives | ☐ Mouth/throat itch | ☐ Dizzy on standing |

What I noticed

Day 7 | Page B: Body, sleep, and energy

Bowel movements, vitality ratings, daily habits, and food trials.

Bowel movements (Bristol Stool Scale)

Number today Check every type you had:

- ☐ 1 Separate hard lumps ☐ 2 Lumpy, sausage-shaped ☐ 3 Sausage with cracks ☐ 4 Smooth, soft sausage
- ☐ 5 Soft blobs, clear edges ☐ 6 Mushy, ragged pieces ☐ 7 Watery, no solid pieces

Types 3-4 are generally considered typical. Types 1-2 suggest constipation; 6-7 suggest loose stools.

Vitality ratings (0-10)

Energy Mood Stress Calm / settled body

Sleep

Bedtime Wake time Hours slept Sleep quality (0-10) Night wakings

Woke between 2 and 4 AM with racing heart, sweating, or vivid dreams? ☐ Yes - note for your provider

Daily habits

Water (cups) Morning outdoor light (min) Screens off at Movement (min)

☐ Ultra-processed foods avoided today ☐ Breathing, humming, or calming practice ☐ Walk after a meal

Supplements and medications taken (name and time)

Food reintroduction trial (one food at a time, with your provider's guidance)

Food tested Amount Time

After 24 hours

After 48 hours

After 72 hours

Notes, experiences, and moments I felt well

Weekly Review

Count your different plant foods and look for patterns to discuss with your providers.

30-plant counter

Write in each different plant food you ate this week: vegetables, fruits, beans and lentils, whole grains, nuts, seeds, herbs, and spices. Each kind counts once, however often you eat it.

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.	

Total different plants this week

Foods I seemed to tolerate well

Possible triggers to discuss with my provider

What helped my energy, sleep, or calm this week

Questions for my doctor, dietitian, or counselor