KLEINBURG
INTEGRATIVE HEALTH

TEL. 905.893.2898
FAX. 1.833.523.2466
RECEPTION@KIHCLINIC.COM

WEEKLY DIET DIARY

NAME: _____ **START DATE:** _____

	Day 1	**Day 2**	**Day 3**	**Day 4**	**Day 5**	**Day 6**
Breakfast						
Lunch						
Dinner						
Snacks **Drinks**						
Mood (on average that day) **Bowel movements** (number/day) **Energy**: 1-10 (10 is good)	M: BM: E:	M: BM: E:	M: BM: E:	M: BM: E:	M: BM: E:	M: BM: E:

Additional Comments:

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