



Diet, Exercise and Sleep Diary **Confidential**

Please take the time to complete the following survey carefully and accurately. List in detail the quantity and the exact nature of all foods and beverages consumed (i.e. frozen, canned, organic, etc.). Please mention if the foods were raw, cooked, or altered. Be sure to list all beverages, all fats or oils and any condiments used (i.e. mayonnaise, mustard, relish, salad dressing, etc.). Please complete the exercise activity portion as well, listing the type of exercise, its duration and your pulse before and during exercising. Also record any periods of relaxation. Please include any supplements (i.e. vitamins, enzymes, etc.) or any medications that you are taking. You may list these on the back of the page.

Day 1		Date:	
Morning Meal Time:		Water (oz/cups) Source	
		Additional Beverages	
Snack			
Noon Meal Time:		Fats/Oils	
		Condiments (sugar/salt/spices, etc.)	
Snack			
Evening Meal Time:		Exercise Type: Duration: Pulse Before: Pulse During:	
		Relaxation Type: Duration:	
Snack			

What time did you go to bed last night? _____

What time did you get up this morning? _____

How was your sleep quality? Sound Restless

Did you awake during the night - Reasons: _____

Did you have night sweats? YES NO

Did you wake up refreshed? _____ Or tired? _____

Are you a slow starter in the morning? YES NO

If Yes, how long does it take to feel alert each morning? _____



Day 2		Date:	
Morning Meal Time:		Water (oz/cups) Source	
Snack		Additional Beverages	
Noon Meal Time:		Fats/Oils	
Snack		Condiments (sugar/salt/spices, etc.)	
Evening Meal Time:		Exercise Type: Duration: Pulse Before: Pulse During:	
Snack		Relaxation Type: Duration:	

What time did you go to bed last night? _____

What time did you get up this morning? _____

How was your sleep quality? Sound Restless

Did you awake during the night - Reasons: _____

Did you have night sweats? YES NO

Did you wake up refreshed? _____ Or tired? _____

Are you a slow starter in the morning? YES NO

If Yes, how long does it take to feel alert each morning? _____



Day 3		Date:	
Morning Meal Time:		Water (oz/cups) Source	
Snack		Additional Beverages	
Noon Meal Time:		Fats/Oils	
Snack		Condiments (sugar/salt/spices, etc.)	
Evening Meal Time:		Exercise Type: Duration: Pulse Before: Pulse During:	
Snack		Relaxation Type: Duration:	

What time did you go to bed last night? _____

What time did you get up this morning? _____

How was your sleep quality? Sound Restless

Did you awake during the night - Reasons: _____

Did you have night sweats? YES NO

Did you wake up refreshed? _____ Or tired? _____

Are you a slow starter in the morning? YES NO

If Yes, how long does it take to feel alert each morning? _____



Day 4		Date:	
Morning Meal Time:		Water (oz/cups) Source	
Snack		Additional Beverages	
Noon Meal Time:		Fats/Oils	
Snack		Condiments (sugar/salt/spices, etc.)	
Evening Meal Time:		Exercise Type: Duration: Pulse Before: Pulse During:	
Snack		Relaxation Type: Duration:	

What time did you go to bed last night? _____

What time did you get up this morning? _____

How was your sleep quality? Sound Restless

Did you awake during the night - Reasons: _____

Did you have night sweats? YES NO

Did you wake up refreshed? _____ Or tired? _____

Are you a slow starter in the morning? YES NO

If Yes, how long does it take to feel alert each morning? _____



Day 5		Date:	
Morning Meal Time:		Water (oz/cups) Source	
Snack		Additional Beverages	
Noon Meal Time:		Fats/Oils	
Snack		Condiments (sugar/salt/spices, etc.)	
Evening Meal Time:		Exercise Type: Duration: Pulse Before: Pulse During:	
Snack		Relaxation Type: Duration:	

What time did you go to bed last night? _____

What time did you get up this morning? _____

How was your sleep quality? Sound Restless

Did you awake during the night - Reasons: _____

Did you have night sweats? YES NO

Did you wake up refreshed? _____ Or tired? _____

Are you a slow starter in the morning? YES NO

If Yes, how long does it take to feel alert each morning? _____



Day 6		Date:	
Morning Meal Time:		Water (oz/cups) Source	
Snack		Additional Beverages	
Noon Meal Time:		Fats/Oils	
Snack		Condiments (sugar/salt/spices, etc.)	
Evening Meal Time:		Exercise Type: Duration: Pulse Before: Pulse During:	
Snack		Relaxation Type: Duration:	

What time did you go to bed last night? _____

What time did you get up this morning? _____

How was your sleep quality? Sound Restless

Did you awake during the night - Reasons: _____

Did you have night sweats? YES NO

Did you wake up refreshed? _____ Or tired? _____

Are you a slow starter in the morning? YES NO

If Yes, how long does it take to feel alert each morning? _____



Day 7		Date:	
Morning Meal Time:		Water (oz/cups) Source	
Snack		Additional Beverages	
Noon Meal Time:		Fats/Oils	
Snack		Condiments (sugar/salt/spices, etc.)	
Evening Meal Time:		Exercise Type: Duration: Pulse Before: Pulse During:	
Snack		Relaxation Type: Duration:	

What time did you go to bed last night? _____

What time did you get up this morning? _____

How was your sleep quality? Sound Restless

Did you awake during the night - Reasons: _____

Did you have night sweats? YES NO

Did you wake up refreshed? _____ Or tired? _____

Are you a slow starter in the morning? YES NO

If Yes, how long does it take to feel alert each morning? _____



Day 8		Date:	
Morning Meal Time:		Water (oz/cups) Source	
Snack		Additional Beverages	
Noon Meal Time:		Fats/Oils	
Snack		Condiments (sugar/salt/spices, etc.)	
Evening Meal Time:		Exercise Type: Duration: Pulse Before: Pulse During:	
Snack		Relaxation Type: Duration:	

What time did you go to bed last night? _____

What time did you get up this morning? _____

How was your sleep quality? Sound Restless

Did you awake during the night - Reasons: _____

Did you have night sweats? YES NO

Did you wake up refreshed? _____ Or tired? _____

Are you a slow starter in the morning? YES NO

If Yes, how long does it take to feel alert each morning? _____



Day 9		Date:	
Morning Meal Time:		Water (oz/cups) Source	
Snack		Additional Beverages	
Noon Meal Time:		Fats/Oils	
Snack		Condiments (sugar/salt/spices, etc.)	
Evening Meal Time:		Exercise Type: Duration: Pulse Before: Pulse During:	
Snack		Relaxation Type: Duration:	

What time did you go to bed last night? _____

What time did you get up this morning? _____

How was your sleep quality? Sound Restless

Did you awake during the night - Reasons: _____

Did you have night sweats? YES NO

Did you wake up refreshed? _____ Or tired? _____

Are you a slow starter in the morning? YES NO

If Yes, how long does it take to feel alert each morning? _____



Day 10		Date:	
Morning Meal Time:		Water (oz/cups) Source	
Snack		Additional Beverages	
Noon Meal Time:		Fats/Oils	
Snack		Condiments (sugar/salt/spices, etc.)	
Evening Meal Time:		Exercise Type: Duration: Pulse Before: Pulse During:	
Snack		Relaxation Type: Duration:	

What time did you go to bed last night? _____

What time did you get up this morning? _____

How was your sleep quality? Sound Restless

Did you awake during the night - Reasons: _____

Did you have night sweats? YES NO

Did you wake up refreshed? _____ Or tired? _____

Are you a slow starter in the morning? YES NO

If Yes, how long does it take to feel alert each morning? _____