

NEW PATIENT CHECKLIST

PLEASE BRING THE FOLLOWING TO YOUR INITIAL VISIT:

- COMPLETED FORMS
- CURRENT COPY OF EKG & LAB RESULTS (IF AVAILABLE)



Welcome to the ***Weight & Wellness Center***! Making the decision to lose weight is the first important step toward achieving your optimal state of wellness. At the ***Weight & Wellness Center***, we believe very strongly in the enormous health benefits of weight loss and are excited to be your partner as you **TRANSFORM YOUR LIFE**.

In order to best utilize your initial consultation, we recommend that you complete and forward all new patient paperwork to us as soon as possible. This enables us to gain a sense of your specific weight loss needs before you even arrive! In an effort to make you feel as comfortable as possible, during your first visit at the ***Weight & Wellness Center***, you can expect the following:

- Complete health history review
- Complete Medical and Bariatric physical
- EKG (if you have a current copy, please bring with you)
- Lab work (if you have current lab results, please bring with you)
- Formulation of a Personalized Weight Loss plan
 - Customized menu plan
 - Individualized exercise plan
 - Personalized weight loss goals

As your ***Weight & Wellness*** team, we are passionate about **YOUR** personal success. As tools to help you succeed, the following items are strongly advised and will be discussed with you at your first visit as to how they will fit into **YOUR** personal weight loss plan:

- Daily use of specific ***Weight & Wellness*** vitamins
- Daily use of a starch blocker before each meal
- Daily use of *Control*® nutritional supplements for appetite suppression
- Weekly ***Weight & Wellness*** vitamin/fat burning injections
- Daily exercise – including use of a pedometer to track your progress
- Maintaining a food and exercise journal
- *The Complete Food Counter*© – reference text for counting calories and protein

We are excited to get started on creating **YOUR** personal plan for weight loss and wellness. Congratulations on joining our team and making the life-changing decision to **TRANSFORM YOUR LIFE!**



Weight & Wellness Center

TRANSFORM Your Life

13901 U.S. Highway 1, STE 5
Juno Beach, FL 33408
Phone: (561) 586-3646 Fax (561) 630-0336

PATIENT INFORMATION

SECTION 1

Name: _____
Last First MI

Prefix Mr. Ms. Mrs. Name: _____ Date of Birth ____/____/____
Nickname Mo Day Year

SS#: _____ Marital Status: Single Married Separated Divorced Widowed

Home Phone: _____ Work: _____ Cell: _____

Address _____
Street City State Zip

Email address: _____ Occupation: _____

Preferred contact and reminder method (circle one): Home Phone Cell Phone Email

SECTION 2

Emergency Contact Name: _____

Phone# _____ Cell# _____ Relationship _____

Address _____
Street City State Zip

Pharmacy Name: _____ Phone: _____

SECTION 3

How did you hear about us?

____ Friend/Current Patient (Please provide name: _____)

____ Doctor Referral (Please provide name: _____)

____ Internet (What website/search engine: _____)

____ Other (Please explain: _____)



Nutrition and Health History

Name: _____ Age: _____ Sex: M F

Primary Care Physician: _____ Physician's Phone #: _____

1. What is the main reason for your decision to lose weight? _____

2. Present Weight _____ Height (no shoes) _____ Desired Weight _____

3. Birth Weight _____

4. In what time frame would you like to be at your desired weight? _____

5. When did you begin gaining excess weight? (Give reasons, if known): _____

6. What has been your maximum lifetime weight (non-pregnant) and when? _____

7. Previous diets you have followed: _____ Give dates and results of your weight loss: _____

8. Is your spouse or partner overweight? YES NO By how much? _____

9. How often do you eat out? _____ How often do you eat "fast foods"? _____

10. What restaurants do you frequent? _____

11. Who plans meals? _____ Cooks? _____ Shops? _____

12. Do you use a shopping list? YES NO

13. Food allergies: _____

14. Food dislikes: _____

15. Food you crave: _____

16. Any specific time of the day or month that you crave food? _____

17. Do you have forbidden foods? _____

18. Do you make yourself sick (vomit or take laxatives) when you feel uncomfortably full? _____

19. Do you binge? _____ What constitutes a binge for you? _____

20. Do you worry you have lost control over how much you eat? _____

21. How often do you weigh yourself? _____

22. When you are under a stressful situation or emotionally upset, do you tend to eat more? Explain: _____

23. Do you think you are currently undergoing a stressful situation or an emotional upset? Explain:

24. Describe your usual energy level: _____

25. What types of exercise do you do? _____

How many days/week do you exercise? _____ For how long? _____

Do you use a pedometer? _____

26. Activity Level (**answer only one**)

_____ Inactive-no regular physical activity with a sit-down job.

_____ Light activity-no organized physical activity during leisure time.

_____ Moderate activity-occasionally involved in activities such as weekend golf, tennis, jogging, cycling.

_____ Heavy activity-consistent lifting, stair climbing, heavy construction, etc. or regular participation in jogging, walking, cycling or active sports at least three times/week.

_____ Vigorous activity-participation in extensive physical exercise for at least 60min at least four/times each week

27. Do you drink coffee or tea? YES NO How much daily? _____

28. Do you drink cola drinks? YES NO How much daily? _____

29. Do you drink alcohol? YES NO What kind? _____

How many drinks? _____ Per Day or Week

30. Do you use sugar substitute? YES NO Butter? YES NO Margarine? YES NO

31. Do you awaken hungry during the night? YES NO

What do you do? _____

32. What are your worst food habits? _____

33. Snack Habits:

What? _____ How much? _____ When? _____

34. What time do you wake up? _____ What time do you go to sleep? _____

CONSENT FOR RELEASE OF MEDICAL RECORDS

PATIENT INFO:

Patient's Name: _____ **Date of Birth:** _____

Social Security Number: _____ Male Female

I authorize (provide names of physicians you wish to release records to Weight & Wellness Center):

NAME: _____ **SPECIALITY:** _____ **PHONE #:** _____ **FAX #:** _____

To:
 Weight & Wellness Center
 13901 US Highway One, Suite 5
 Juno Beach, FL 33408
 (561) 586-3646 Fax (561) 630-0336

This office has attested for Meaningful Use and requests records be sent electronically in CCD or CCR format. Please send via email to info@junoweightloss.com. Kindly password protect data by using the password "lose10". If unable to provide info electronically, requested records can be sent via fax.

For dates of service from _____ to _____

CCD/CCR data must include: Diagnostic Test Results, Problem List, Medication List and Allergy List

Please provide the following additional information (check all that apply):

EKG Special procedures reports Other _____

For purposes of:

- Assisting the above recipient in coordination of my health care
- At the request of the individual

I request my medical information to be released to the Weight & Wellness Center in compliance with HIPPA guidelines. I understand that this information will be released to any additional party without proper authorization or the properly signed court order of an appropriate judge. This authorization is valid for one transfer of information only from the noted offices as signed on the date below and as such will expire in **30 days** from the signature. This information will be used for continuity of care. I understand that this authorization may be revoked at any time by giving written notice to the medical office

Signature of Patient or Legal Guardian

 Relationship to Patient

 Print Name of Legal Guardian, if applicable

Three Reasons “Why I Want to Reach My Goal Weight”

Name: _____

Date: _____

Before writing your reasons down, give them some thought. It is important that these three reasons be true personal goals and desires. They should not be generalizations or what you think would please others because they will be used as your “personal motivator.”

Take a few moments from time to time each day to thoughtfully read through this list. This is called mental programming. The original of your three lists is retained in your medical file. You will be given a copy to carry at all times. We suggest that you also transfer your list onto a 3x5 card which may be more convenient.

Make a promise to yourself now: “I will read the entire card whenever I am confronted with a difficult food situation.” Reading the list will clearly reinforce your personal commitment to take control of your health and self-esteem.

1. _____

2. _____

3. _____

Exercise Consent & Agreement

I, _____, understand that some form of cardiovascular (aerobic) exercise is a key component to my weight loss and wellness program.

The Weight & Wellness Center has found that patients who comply with exercise guidelines can have double the amount of fat loss per week.

I understand exercise programming will be prescribed to each patient's capability and fitness levels and I am willing to follow these suggestions to the best of my ability.

Patient Signature (Or person with authority to consent for patient)

Patient Name (please print)

Date

Please list any medical or orthopedic problems that may interfere with an exercise program.



Weight-Loss Consumer Bill of Rights

WARNING: Rapid weight loss may cause serious health problems. Rapid weight loss is weight loss of more than 1 ½ pounds to 2 pounds per week or weight loss of more than 1 percent of body weight per week after the second week of participation in a weight-loss program. Consult your personal physician before starting any weight-loss program. Only permanent lifestyle changes, such as making healthful food choices and increasing physical activity, promote long-term weight loss. Qualifications of this provider are available upon request. You have a right to: ask questions about the potential health risk of this program and its nutritional content, psychological support, and educational components; receive an itemized statement of the actual or estimated price of this weight-loss program, including extra products, services, supplements, examinations and laboratory tests; know the actual or estimated duration of the program. You, the patient, is under no obligation whatsoever to purchase supplements from the Weight & Wellness Center. Food products, supplements, injections and all other products are sold for profit.

Required to be posted by section 501.0575 of Florida Statutes.

Initial: _____ Date: _____

Wellness Program Consent Form

I, _____, authorize Holly W. Hadley M.D. and whomever she designates as her assistants, to help me in my wellness efforts. I understand that my program may consist of a personalized diet, a regular exercise program, instruction in behavior modification techniques, and may involve the use of herbal or nutraceutical medications. As these medications are non-prescription, they are not governed by the FDA but rather the DSHEA of 1991. All can be obtained over the counter, however, The Weight & Wellness Center may offer physician grade supplements.

I understand that any medical treatment may involve risks as well as the proposed benefits. Risks of this program may include but are not limited to nervousness, sleeplessness, headaches, dry mouth, gastrointestinal disturbances, weakness, tiredness, psychological problems, high blood pressure, rapid heart beat, and heart irregularities. These and other possible risks could, on occasion, be serious or even fatal.

I understand that much of the success of the program will depend on my efforts and that there are no guarantees or assurances that the program will be successful. Changes in eating habits and permanent changes in behavior may be needed to be treated successfully. I also understand that I will have to continue watching my weight all of my life if I am to be successful.

I have read and fully understand this consent form and realize I should not sign this form if all items have not been explained to me. My questions have been answered to my complete satisfaction. I have been urged and have been given all the time I need to read and understand this form.

If you have any questions regarding the risks or hazards of the proposed treatment, or any questions whatsoever concerning the proposed treatment or other possible treatments, ask your doctor or nurse practitioner now before signing this consent form.

Initial: _____ Date: _____

Insurance Disclaimer

I understand that Holly W. Hadley M.D. does not participate with any insurance programs, and my visit fees are due at the time of the visit. Further, lab work ordered may not be covered by my insurance; and, I can choose to pay Weight & Wellness Center for lab work done in office, pay an outside lab, or request the labs through my primary care physician.

I understand controlled substances can only be obtained with a regular monthly visit with Dr. Hadley.

Initial: _____ Date: _____

Financial Policy

Thank you for selecting The Weight & Wellness Center for your health care needs. We are honored to be of service to you and your family. This is to inform you of our billing requirements and our financial policy. Please be advised that payment for all services will be due at the time services are rendered. For your convenience we accept credit cards, checks and cash.

I have read and understand all of the above and have agreed to these arrangements.

Initial: _____ Date: _____

Cancellation and Lapse in Care policy

Holly W. Hadley M.D attempts to accommodate everyone's schedule. All visits, including weekly weight checks, are by appointment only. Appointments must be cancelled with 24 hour ADVANCE notice. Failure to do so will result in the full fee.

Additionally, if routine care lapses for more than six (6) months, an appointment to become re-established will be necessary with its associated fees.

Patient Signature (Or person with authority to consent for patient)

Patient Name (please print)

Date

Name _____ Sex: M F Date of Birth _____ Today's Date _____

Allergies	Reaction	Current Medications, Vitamins, Supplements	Dose	Times/day
1) _____	_____	1) _____	_____	_____
2) _____	_____	2) _____	_____	_____
3) _____	_____	3) _____	_____	_____
4) _____	_____	4) _____	_____	_____
5) _____	_____	5) _____	_____	_____

Past Medical History

<input type="checkbox"/> Diabetes Type I Type II	<input type="checkbox"/> Headaches	<input type="checkbox"/> Pap (mo/yr) _____	<input type="checkbox"/> Prostate exam (mo/yr) _____
<input type="checkbox"/> Cancer _____	<input type="checkbox"/> Neck Problems	<input type="checkbox"/> Mammogram (mo/yr) _____	<input type="checkbox"/> Colonoscopy (mo/yr) _____
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Back Problems	Specialists (Seen regularly)	<input type="checkbox"/> Bone Density Test (mo/yr) _____
<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Rheumatoid arthritis	<input type="checkbox"/> Cardiologist _____	<input type="checkbox"/> Chiropractor _____
<input type="checkbox"/> Heart attack	<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Allergist _____	<input type="checkbox"/> Other _____
<input type="checkbox"/> Other heart trouble	<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Pulmonologist _____	<input type="checkbox"/> Other _____
<input type="checkbox"/> Asthma	<input type="checkbox"/> Esophageal reflux (GERD)	(Females only) <input type="checkbox"/> Menopause # Full term pregnancies _____ During pregnancy did # you have: # C-sections _____ <input type="checkbox"/> High blood pressure # Vaginal deliveries _____ <input type="checkbox"/> Diabetes # Miscarriages/abortions _____ <input type="checkbox"/> Pre-eclampsia or eclampsia	
<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Kidney/bladder disease		
<input type="checkbox"/> Stroke	<input type="checkbox"/> Hepatitis		
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Peptic ulcer		
<input type="checkbox"/> Anemia	<input type="checkbox"/> Appendicitis		
<input type="checkbox"/> Thyroid problems	<input type="checkbox"/> Other stomach/bowel disease		
<input type="checkbox"/> Chicken pox	Immunizations:		
<input type="checkbox"/> Valley fever	<input type="checkbox"/> Polio vac (year) _____		
<input type="checkbox"/> Tuberculosis/ (+) skin test	<input type="checkbox"/> MMR vac (year) _____		
<input type="checkbox"/> Depression/anxiety	<input type="checkbox"/> DPT vac (year) _____		
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Chicken Pox Vaccine		
<input type="checkbox"/> Fractures _____	<input type="checkbox"/> Flu Shot in last 12 months		
<input type="checkbox"/> Sexually transmitted disease	<input type="checkbox"/> Pneumovax (year) _____		
	<input type="checkbox"/> Tetanus (year) _____		
	<input type="checkbox"/> Hep B vac (year) _____		
	<input type="checkbox"/> Gardasil (year) _____		

Surgical History

<input type="checkbox"/> Tonsillectomy	<input type="checkbox"/> Appendectomy	<input type="checkbox"/> Gallbladder surgery	<input type="checkbox"/> Other _____
<input type="checkbox"/> Knee Surgery R () L ()	<input type="checkbox"/> Hip surgery R () L ()	<input type="checkbox"/> Thyroid surgery	<input type="checkbox"/> Other _____
<input type="checkbox"/> Hysterectomy	<input type="checkbox"/> Prostate surgery	<input type="checkbox"/> Vasectomy	<input type="checkbox"/> Other _____
<input type="checkbox"/> Shoulder surgery R () L ()	<input type="checkbox"/> Heart bypass	<input type="checkbox"/> Cataract R () L ()	<input type="checkbox"/> Other _____
<input type="checkbox"/> Hernia repair	<input type="checkbox"/> Back surgery	<input type="checkbox"/> Breast surgery/biopsy	<input type="checkbox"/> Other _____
<input type="checkbox"/> C-section			

Family History (Circle major medical problems)

Mother	Diabetes	Colon cancer	Breast cancer	High blood pressure	Early heart attack	Other _____
Father	Diabetes	Colon cancer	Breast cancer	High blood pressure	Early heart attack	Other _____
Brothers	Diabetes	Colon cancer	Breast cancer	High blood pressure	Early heart attack	Other _____
Sisters	Diabetes	Colon cancer	Breast cancer	High blood pressure	Early heart attack	Other _____
Children	Diabetes	Colon cancer	Breast cancer	High blood pressure	Early heart attack	Other _____
Maternal Grandmother	Diabetes	Colon cancer	Breast cancer	High blood pressure	Early heart attack	Other _____
Paternal Grandmother	Diabetes	Colon cancer	Breast cancer	High blood pressure	Early heart attack	Other _____
Maternal Grandfather	Diabetes	Colon cancer	Breast cancer	High blood pressure	Early heart attack	Other _____
Paternal Grandfather	Diabetes	Colon cancer	Breast cancer	High blood pressure	Early heart attack	Other _____

Social History

Occupation _____ Hobbies/Activities _____

Marital status: Single Married Widowed Divorced Separated

Tobacco Never # per day _____ Alcohol use: Never or Liquor _____ per day / week / month
 Now
 Quit Year quit _____ Rec. Drugs: Never Beer _____ per day / week / month
Age started _____ Now Wine _____ per day / week / month
 In past

Rate each of the following symptoms based upon your typical health profile **FOR THE PAST 30 DAYS**
 (if you are dealing with more than one symptom listed below then please circle all that apply):

NAME _____ DATE _____

Please use the scale shown below to describe the severity of your symptom (please total each section)

- | | |
|---|---|
| 0 <i>Never or almost never</i> have the symptom | 3 <i>Frequently</i> have it, effect is <i>not severe</i> |
| 1 <i>Occasionally</i> have it, effect is <i>not severe</i> | 4 <i>Frequently</i> have it, effect is <i>severe</i> |
| 2 <i>Occasionally</i> have it, effect is <i>severe</i> | |

HEAD _____ Headaches
 _____ Dizziness/Faintness
 _____ Insomnia
 _____ **TOTAL (this section)**

EYES _____ Watery or itchy eyes
 _____ Swollen, reddened or sticky eyelids
 _____ Dark circles under eyes
 _____ Vision problems
 (excluding near or farsighted)
 _____ **TOTAL (this section)**

EARS _____ Itchy ears
 _____ Frequent ear infections
 _____ Popping of ears
 _____ Ringing in ears
 _____ **TOTAL (this section)**

NOSE _____ Stuffy nose/Excessive mucus formation
 _____ Sinus problems
 _____ Hay fever/Sneezing attacks
 _____ Nose bleeding
 _____ **TOTAL (this section)**

MOUTH/ _____ Gagging, frequent need to clear throat
 _____ Sore throat, hoarseness, loss of voice
 _____ Swollen/Discolored tongue, gums, lips
 _____ Canker sores
 _____ **TOTAL (this section)**

SKIN _____ Acne
 _____ Hives, rashes, dry skin
 _____ Hair loss
 _____ Excessive hair growth
 _____ Excessive sweating/Body odor
 _____ Flushing, hot flashes
 _____ **TOTAL (this section)**

HEART _____ Irregular or skipped heartbeat
 _____ Rapid or pounding heartbeat
 _____ Chest pain
 _____ **TOTAL (this section)**

LUNGS _____ Chest congestion
 _____ Asthma, frequent bronchitis
 _____ Difficulty breathing
 _____ Frequent coughing
 _____ **TOTAL (this section)**

DIGESTIVE TRACT _____ Nausea, vomiting
 _____ Diarrhea, loose stools
 _____ Constipation, hard/infrequent stools
 _____ Bloating feeling
 _____ Belching, passing gas, burping
 _____ Heartburn/acid taste in mouth
 _____ Intestinal/stomach pain
 _____ **TOTAL (this section)**

JOINTS / MUSCLE _____ Pain or aches in joints/Arthritis
 _____ Warm, swollen joints
 _____ Stiffness or limitation of movement
 _____ Pain or aches in muscles
 _____ Muscle weakness
 _____ **TOTAL (this section)**

WEIGHT _____ Excessive eating/drinking
 _____ Strong/Excessive craving certain foods
 _____ Overweight/Obese
 _____ Difficulty losing weight
 _____ Water retention
 _____ Difficulty gaining weight
 _____ **TOTAL (this section)**

ENERGY / ACTIVITY _____ Fatigue from physical exhaustion
 _____ Fatigue from emotional exhaustion
 _____ Hyperactivity (mind or body)
 _____ Restlessness (mind or body)
 _____ **TOTAL (this section)**

MIND _____ Poor memory
 _____ Confusion, poor comprehension
 _____ Poor concentration
 _____ Poor physical coordination
 _____ Difficulty making decisions
 _____ Speech difficulty
 _____ Learning disabilities
 _____ **TOTAL (this section)**

EMOTIONS _____ Mood swings
 _____ Anxiety, fear, nervousness
 _____ Anger, irritability, aggressiveness
 _____ Depression/Sadness
 _____ Obsessive, compulsive behaviors
 _____ **TOTAL (this section)**

OTHER _____ Frequent illness
 _____ Frequent or urgent urination
 _____ Genital itch or discharge
 _____ **TOTAL (this section)**

SUM OF ALL SECTIONS ABOVE:

3 Day Diet Diary

Instructions for Completing the Diet Diary

A diet diary is a record of your food and beverage intake. Maintaining an accurate diary is a very important part of your care. Please complete this Diet Diary for three consecutive days with one day being a weekend day.

- Record information as soon as possible after the food has been consumed.
- Do not change your eating behavior at this time unless advised by a health practitioner. The purpose of this food record is to analyze your current eating habits.
- Describe the food or beverage consumed. e.g., milk - what kind? (soy, almond, whole, 2%, or nonfat, etc.); toast - (whole wheat, white, buttered); chicken - (fried, baked, breaded), etc.
- Record the amount of each food consumed using standard measurements as much as possible, such as 8 ounces, 1/2 cup, 1 teaspoon, etc.
- Include any added items. For example: tea with 1 teaspoon sugar, potato with 2 teaspoons butter, etc.
- Please record all beverages and their amounts, including water. List them in the “Beverage” category.
- Record any exercise you get each day, including the type of activity and its duration
- Please record all bowel movements and their consistency (regular, loose, firm, etc.).
- Note any changes in your symptoms throughout the three day period in the “Symptoms” area of the diary.



Diet Diary Day 2

Name _____

Date _____

Time	Food	Amount
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
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_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Time	Beverage	Amount
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Time	Exercise: Type
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Time	Bowel Movements: Consistency
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Time	Symptoms: Describe (e.g. anxiety, lethargic, headache)
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Diet Diary Day 3

Name _____

Date _____

Time	Food	Amount
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Time	Beverage	Amount
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Time	Exercise: Type
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Time	Bowel Movements: Consistency
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Time	Symptoms: Describe (e.g. anxiety, lethargic, headache)
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____