CHEK INSTITUTE
DIET, EXERCISE AND SLEEP DIARY

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

Client Name: _____

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? ☐ Yes ☐ No Time(s) _____

Reason(s) why? _____

Did you have night sweats? ☐ Yes ☐ No

Did you wake up refreshed today or tired? ☐ Refreshed ☐ Tired

Did you start slow this morning? ☐ Yes ☐ No

If Yes, how long did it take you to feel alert? _____

Bowel movement(s)? Number? _____ Color? _____

Size and Shape? _____

Day 2

Client Name: _____

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? ☐ Yes ☐ No Time(s) _____

Reason(s) why? _____

Did you have night sweats? ☐ Yes ☐ No

Did you wake up refreshed today or tired? ☐ Refreshed ☐ Tired

Did you start slow this morning? ☐ Yes ☐ No

If Yes, how long did it take you to feel alert? _____

Bowel movement(s)? Number? _____ Color? _____

Size and Shape? _____

Day 3

Client Name: _____

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? ☐ Yes ☐ No Time(s) _____

Reason(s) why? _____

Did you have night sweats? ☐ Yes ☐ No

Did you wake up refreshed today or tired? ☐ Refreshed ☐ Tired

Did you start slow this morning? ☐ Yes ☐ No

If Yes, how long did it take you to feel alert? _____

Bowel movement(s)? Number? _____ Color? _____

Size and Shape? _____

Day 4

Client Name: _____

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? ☐ Yes ☐ No Time(s) _____

Reason(s) why? _____

Did you have night sweats? ☐ Yes ☐ No

Did you wake up refreshed today or tired? ☐ Refreshed ☐ Tired

Did you start slow this morning? ☐ Yes ☐ No

If Yes, how long did it take you to feel alert? _____

Bowel movement(s)? Number? _____ Color? _____

Size and Shape? _____

Day 5

Client Name: _____

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? ☐ Yes ☐ No Time(s) _____

Reason(s) why? _____

Did you have night sweats? ☐ Yes ☐ No

Did you wake up refreshed today or tired? ☐ Refreshed ☐ Tired

Did you start slow this morning? ☐ Yes ☐ No

If Yes, how long did it take you to feel alert? _____

Bowel movement(s)? Number? _____ Color? _____

Size and Shape? _____

Day 6

Client Name: _____

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? ☐ Yes ☐ No Time(s) _____

Reason(s) why? _____

Did you have night sweats? ☐ Yes ☐ No

Did you wake up refreshed today or tired? ☐ Refreshed ☐ Tired

Did you start slow this morning? ☐ Yes ☐ No

If Yes, how long did it take you to feel alert? _____

Bowel movement(s)? Number? _____ Color? _____

Size and Shape? _____

Day 7

Client Name: _____

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? ☐ Yes ☐ No Time(s) _____

Reason(s) why? _____

Did you have night sweats? ☐ Yes ☐ No

Did you wake up refreshed today or tired? ☐ Refreshed ☐ Tired

Did you start slow this morning? ☐ Yes ☐ No

If Yes, how long did it take you to feel alert? _____

Bowel movement(s)? Number? _____ Color? _____

Size and Shape? _____

Day 8

Client Name: _____

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? ☐ Yes ☐ No Time(s) _____

Reason(s) why? _____

Did you have night sweats? ☐ Yes ☐ No

Did you wake up refreshed today or tired? ☐ Refreshed ☐ Tired

Did you start slow this morning? ☐ Yes ☐ No

If Yes, how long did it take you to feel alert? _____

Bowel movement(s)? Number? _____ Color? _____

Size and Shape? _____

Day 9

Client Name: _____

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? ☐ Yes ☐ No Time(s) _____

Reason(s) why? _____

Did you have night sweats? ☐ Yes ☐ No

Did you wake up refreshed today or tired? ☐ Refreshed ☐ Tired

Did you start slow this morning? ☐ Yes ☐ No

If Yes, how long did it take you to feel alert? _____

Bowel movement(s)? Number? _____ Color? _____

Size and Shape? _____

Day 10

Client Name: _____

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? ☐ Yes ☐ No Time(s) _____

Reason(s) why? _____

Did you have night sweats? ☐ Yes ☐ No

Did you wake up refreshed today or tired? ☐ Refreshed ☐ Tired

Did you start slow this morning? ☐ Yes ☐ No

If Yes, how long did it take you to feel alert? _____

Bowel movement(s)? Number? _____ Color? _____

Size and Shape? _____