



C.H.E.K 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.

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Client Name: _____

Day 1		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? 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? _____



Client Name: _____

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



Client Name: _____

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



Client Name: _____

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



Client Name: _____

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



Client Name: _____

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



Client Name: _____

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



Client Name: _____

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



Client Name: _____

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? 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? _____



Client Name: _____

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? 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? _____