

## WEEK IN REVIEW

Name \_\_\_\_\_ Date \_\_\_\_\_ Weeks since last visit \_\_\_\_\_

**Nutrition:** Average number of servings per day of animal and vegetable proteins

Legumes \_\_\_\_\_ Grains \_\_\_\_\_ Vegetables \_\_\_\_\_ Fruits \_\_\_\_\_ Starch Vegetables \_\_\_\_\_

Healthy fats \_\_\_\_\_ Protein shakes \_\_\_\_\_ 15gm bars \_\_\_\_\_

How many times have you eaten outside your home? \_\_\_\_\_

**Appetite suppressants** (if applicable): Any problems with hunger? Y N Any side effects? Y N

If yes, please describe: \_\_\_\_\_

**Supplements:** Y N If yes, please specify:

Magnesium \_\_\_\_\_ Potassium \_\_\_\_\_ Omega 3 \_\_\_\_\_ Multi \_\_\_\_\_ Probiotic \_\_\_\_\_ Enzyme \_\_\_\_\_

**Activity:** Type \_\_\_\_\_ Amount \_\_\_\_\_

**Life Skills** (new or improved): \_\_\_\_\_

**Goals** (for coming week): \_\_\_\_\_

Any symptoms or physical problems? Y N If yes, please describe: \_\_\_\_\_

\_\_\_\_\_

Any major stressful situations? Y N If yes, please describe: \_\_\_\_\_

\_\_\_\_\_

Have you received any medical care this week? Y N

If yes, where and why?: \_\_\_\_\_

Any problems adhering to the program? Y N If yes, please describe: \_\_\_\_\_

\_\_\_\_\_

Date of onset of last menstrual period: \_\_\_\_\_ (please circle if not applicable) N/A

**For Practitioner**

See next page \_\_\_\_\_ (init)