



WEEK IN REVIEW

Name _____ Date _____ Weeks since last visit _____

Nutrition: Average number of servings per day:

Protein shakes _____ Meat _____ Bars _____ Healthy Fats _____ Fruits & Starch _____

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

If yes, please describe _____

Supplements: **Y N** Sodium _____ Potassium _____ Comments _____

Activity: Type _____ Amount _____

Life Skills (new or improved) _____

Goals (for coming week) _____

Any symptoms or physical problems? **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 indicate if not applicable) **N/A**

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BP: P: Weight change since last visit Total

S:

O: Appearance Mood and affect Sleep

A:

P: