

WEEKLY RECORD JOURNAL

NAME: ----- TODAY'S DATE: -----

My Eating Habits (daily)

 **NOTE:** Please make 7 copies of My Eating Habits for each day of one week


Morning	Breakfast	am Snack	Lunch	pm Snack	Dinner


Medicine (if you are taking any)

Morning: -----
Breakfast: -----
Lunch: -----
Dinner: -----
Between Meals/on an empty stomach: -----


Supplements:


Morning: -----
Breakfast: -----
Lunch: -----
Dinner: -----
Between Meals/on an empty stomach: -----

 **Water/Beverage (cups/day):** -----

 **Bowel Movement (times/day):** -----

 **Breathing Exercise (times/day):** -----

 **Please record any symptoms you might have including migraine headaches daily:** -----

 **NOTE:** Keep the list of Migraine Triggers under your sight, take notes of any allergy reaction (early or late reaction), and keep record of your daily symptoms.

My PMS Calendar (monthly)

Month: -----Year: -----

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY

Commitment is Your Only Way to Recovery!