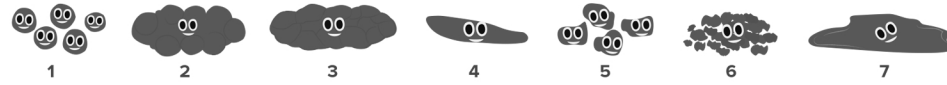
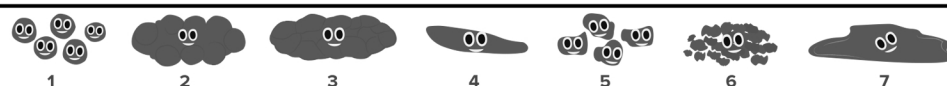


Use this journal to get a better sense of your digestive health! Fill out the food and mood portion after each meal, and update the water intake, bowel movements and other symptoms sections throughout the day.

Date: _____

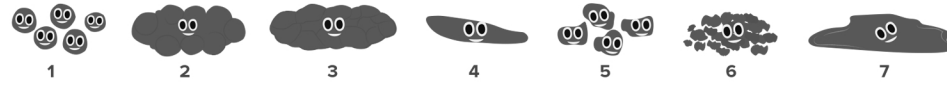
	Time	What Did You Eat?	How Did You Feel?	Other
Breakfast	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Lunch	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Dinner	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Snack/Other	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Track Your Water How many glasses?	<input type="text"/> 1 <input type="text"/> 2 <input type="text"/> 3 <input type="text"/> 4 <input type="text"/> 5 <input type="text"/> 6 <input type="text"/> 7 <input type="text"/> 8 <input type="text"/> 9 <input type="text"/> 10 <input type="text"/> 11 <input type="text"/> 12 <input type="text"/> 13 <input type="text"/> 14 <input type="text"/> 15			
Bristol Stool Types				
Track Your BMs	Time	Bristol Type #	Other Notes (color, smell, pain, gas, floaters, etc.)	
	<input type="text"/>	<input type="text"/>	<input type="text"/>	
	<input type="text"/>	<input type="text"/>	<input type="text"/>	
	<input type="text"/>	<input type="text"/>	<input type="text"/>	
	<input type="text"/>	<input type="text"/>	<input type="text"/>	
	<input type="text"/>	<input type="text"/>	<input type="text"/>	
	<input type="text"/>	<input type="text"/>	<input type="text"/>	
	<input type="text"/>	<input type="text"/>	<input type="text"/>	
Other Notes and Symptoms (pain, cramping, bloating, gas, stress, mood changes, etc.)	Time	Notes/Symptoms		
	<input type="text"/>	<input type="text"/>		
	<input type="text"/>	<input type="text"/>		
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	<input type="text"/>	<input type="text"/>		
	<input type="text"/>	<input type="text"/>		

Date: _____

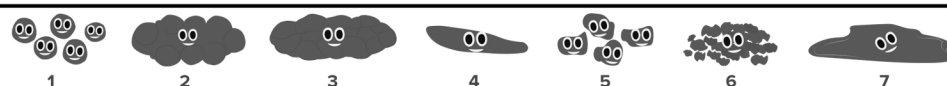
	Time	What Did You Eat?	How Did You Feel?	Other
Breakfast	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Lunch	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Dinner	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Snack/Other	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Track Your Water How many glasses?	<input type="text"/> 1 <input type="text"/> 2 <input type="text"/> 3 <input type="text"/> 4 <input type="text"/> 5 <input type="text"/> 6 <input type="text"/> 7 <input type="text"/> 8 <input type="text"/> 9 <input type="text"/> 10 <input type="text"/> 11 <input type="text"/> 12 <input type="text"/> 13 <input type="text"/> 14 <input type="text"/> 15			
Bristol Stool Types				
Track Your BMs	Time	Bristol Type #	Other Notes (color, smell, pain, gas, floaters, etc.)	
	<input type="text"/>	<input type="text"/>	<input type="text"/>	
	<input type="text"/>	<input type="text"/>	<input type="text"/>	
	<input type="text"/>	<input type="text"/>	<input type="text"/>	
	<input type="text"/>	<input type="text"/>	<input type="text"/>	
	<input type="text"/>	<input type="text"/>	<input type="text"/>	
	<input type="text"/>	<input type="text"/>	<input type="text"/>	
Other Notes and Symptoms (pain, cramping, bloating, gas, stress, mood changes, etc.)	Time	Notes/Symptoms		
	<input type="text"/>	<input type="text"/>		
	<input type="text"/>	<input type="text"/>		
	<input type="text"/>	<input type="text"/>		
	<input type="text"/>	<input type="text"/>		
	<input type="text"/>	<input type="text"/>		

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Date: _____

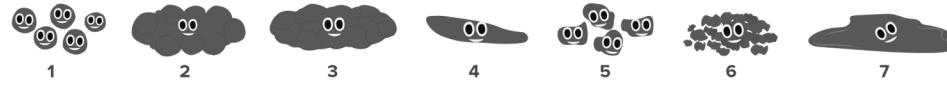
	Time	What Did You Eat?	How Did You Feel?	Other
Breakfast	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Lunch	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Dinner	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Snack/Other	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Track Your Water How many glasses?	<input type="text"/> 1 <input type="text"/> 2 <input type="text"/> 3 <input type="text"/> 4 <input type="text"/> 5 <input type="text"/> 6 <input type="text"/> 7 <input type="text"/> 8 <input type="text"/> 9 <input type="text"/> 10 <input type="text"/> 11 <input type="text"/> 12 <input type="text"/> 13 <input type="text"/> 14 <input type="text"/> 15			
Bristol Stool Types				
Track Your BMs	Time	Bristol Type #	Other Notes (color, smell, pain, gas, floaters, etc.)	
	<input type="text"/>	<input type="text"/>	<input type="text"/>	
	<input type="text"/>	<input type="text"/>	<input type="text"/>	
	<input type="text"/>	<input type="text"/>	<input type="text"/>	
	<input type="text"/>	<input type="text"/>	<input type="text"/>	
	<input type="text"/>	<input type="text"/>	<input type="text"/>	
	<input type="text"/>	<input type="text"/>	<input type="text"/>	
Other Notes and Symptoms (pain, cramping, bloating, gas, stress, mood changes, etc.)	Time	Notes/Symptoms		
	<input type="text"/>	<input type="text"/>		
	<input type="text"/>	<input type="text"/>		
	<input type="text"/>	<input type="text"/>		
	<input type="text"/>	<input type="text"/>		
	<input type="text"/>	<input type="text"/>		

Date: _____

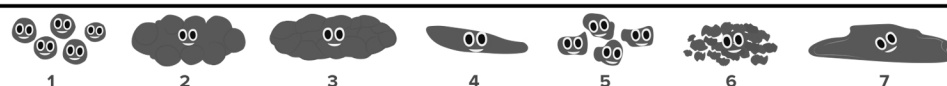
	Time	What Did You Eat?	How Did You Feel?	Other
Breakfast	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Lunch	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Dinner	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Snack/Other	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Track Your Water How many glasses?	<input type="text"/> 1 <input type="text"/> 2 <input type="text"/> 3 <input type="text"/> 4 <input type="text"/> 5 <input type="text"/> 6 <input type="text"/> 7 <input type="text"/> 8 <input type="text"/> 9 <input type="text"/> 10 <input type="text"/> 11 <input type="text"/> 12 <input type="text"/> 13 <input type="text"/> 14 <input type="text"/> 15			
Bristol Stool Types				
Track Your BMs	Time	Bristol Type #	Other Notes (color, smell, pain, gas, floaters, etc.)	
	<input type="text"/>	<input type="text"/>	<input type="text"/>	
	<input type="text"/>	<input type="text"/>	<input type="text"/>	
	<input type="text"/>	<input type="text"/>	<input type="text"/>	
	<input type="text"/>	<input type="text"/>	<input type="text"/>	
	<input type="text"/>	<input type="text"/>	<input type="text"/>	
Other Notes and Symptoms (pain, cramping, bloating, gas, stress, mood changes, etc.)	Time	Notes/Symptoms		
	<input type="text"/>	<input type="text"/>		
	<input type="text"/>	<input type="text"/>		
	<input type="text"/>	<input type="text"/>		
	<input type="text"/>	<input type="text"/>		
	<input type="text"/>	<input type="text"/>		

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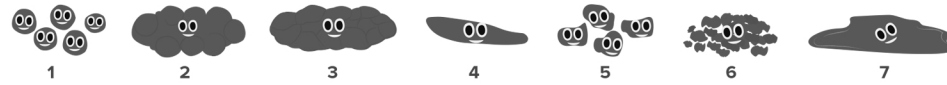
Date: _____

	Time	What Did You Eat?	How Did You Feel?	Other
Breakfast	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Lunch	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Dinner	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Snack/Other	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Track Your Water How many glasses?	<input type="text"/> 1 <input type="text"/> 2 <input type="text"/> 3 <input type="text"/> 4 <input type="text"/> 5 <input type="text"/> 6 <input type="text"/> 7 <input type="text"/> 8 <input type="text"/> 9 <input type="text"/> 10 <input type="text"/> 11 <input type="text"/> 12 <input type="text"/> 13 <input type="text"/> 14 <input type="text"/> 15			
Bristol Stool Types				
Track Your BMs	Time	Bristol Type #	Other Notes (color, smell, pain, gas, floaters, etc.)	
	<input type="text"/>	<input type="text"/>	<input type="text"/>	
	<input type="text"/>	<input type="text"/>	<input type="text"/>	
	<input type="text"/>	<input type="text"/>	<input type="text"/>	
	<input type="text"/>	<input type="text"/>	<input type="text"/>	
	<input type="text"/>	<input type="text"/>	<input type="text"/>	
	<input type="text"/>	<input type="text"/>	<input type="text"/>	
	<input type="text"/>	<input type="text"/>	<input type="text"/>	
Other Notes and Symptoms (pain, cramping, bloating, gas, stress, mood changes, etc.)	Time	Notes/Symptoms		
	<input type="text"/>	<input type="text"/>		
	<input type="text"/>	<input type="text"/>		
	<input type="text"/>	<input type="text"/>		
	<input type="text"/>	<input type="text"/>		
	<input type="text"/>	<input type="text"/>		

Date: _____

	Time	What Did You Eat?	How Did You Feel?	Other
Breakfast	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Lunch	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Dinner	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Snack/Other	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Track Your Water How many glasses?	<input type="text"/> 1 <input type="text"/> 2 <input type="text"/> 3 <input type="text"/> 4 <input type="text"/> 5 <input type="text"/> 6 <input type="text"/> 7 <input type="text"/> 8 <input type="text"/> 9 <input type="text"/> 10 <input type="text"/> 11 <input type="text"/> 12 <input type="text"/> 13 <input type="text"/> 14 <input type="text"/> 15			
Bristol Stool Types				
Track Your BMs	Time	Bristol Type #	Other Notes (color, smell, pain, gas, floaters, etc.)	
	<input type="text"/>	<input type="text"/>	<input type="text"/>	
	<input type="text"/>	<input type="text"/>	<input type="text"/>	
	<input type="text"/>	<input type="text"/>	<input type="text"/>	
	<input type="text"/>	<input type="text"/>	<input type="text"/>	
	<input type="text"/>	<input type="text"/>	<input type="text"/>	
	<input type="text"/>	<input type="text"/>	<input type="text"/>	
Other Notes and Symptoms (pain, cramping, bloating, gas, stress, mood changes, etc.)	Time	Notes/Symptoms		
	<input type="text"/>	<input type="text"/>		
	<input type="text"/>	<input type="text"/>		
	<input type="text"/>	<input type="text"/>		
	<input type="text"/>	<input type="text"/>		
	<input type="text"/>	<input type="text"/>		

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Date			
	Time	What Did You Eat?	How Did You Feel?
Breakfast	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input type="checkbox"/> 😊 <input type="checkbox"/> 😐 <input type="checkbox"/> 😞 <input type="checkbox"/> 🤢 <input type="checkbox"/> 🤮 <input type="checkbox"/> 🤧 <input type="checkbox"/> 🤨
Lunch	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input type="checkbox"/> 😊 <input type="checkbox"/> 😐 <input type="checkbox"/> 😞 <input type="checkbox"/> 🤢 <input type="checkbox"/> 🤮 <input type="checkbox"/> 🤧 <input type="checkbox"/> 🤨
Dinner	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input type="checkbox"/> 😊 <input type="checkbox"/> 😐 <input type="checkbox"/> 😞 <input type="checkbox"/> 🤢 <input type="checkbox"/> 🤮 <input type="checkbox"/> 🤧 <input type="checkbox"/> 🤨
Snack/Other	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input type="checkbox"/> 😊 <input type="checkbox"/> 😐 <input type="checkbox"/> 😞 <input type="checkbox"/> 🤢 <input type="checkbox"/> 🤮 <input type="checkbox"/> 🤧 <input type="checkbox"/> 🤨
Track Your Water How many glasses?	<input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12 <input type="checkbox"/> 13 <input type="checkbox"/> 14 <input type="checkbox"/> 15		
Bristol Stool Types			
	Time	Bristol Type #	Other Notes (color, smell, pain, gas, floaters, etc.)
Track Your BMs Rate them using the scale above, from 1 (constipation) to 7 (diarrhea); 4 is ideal	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
Other Notes and Symptoms (pain, cramping, bloating, gas, stress, mood changes, etc.)	Time		
	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	
	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	
	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	
	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	
	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	