

## **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.



**Diet, Exercise and Sleep Diary**  
**Confidential**

**Day 1**

**Client Name:** \_\_\_\_\_

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? \_\_\_\_\_



**Diet, Exercise and Sleep Diary**  
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**Day 2**

**Client Name:** \_\_\_\_\_

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? \_\_\_\_\_



**Diet, Exercise and Sleep Diary**  
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**Day 3**

**Client Name:** \_\_\_\_\_

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? \_\_\_\_\_



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**Day 4**

**Client Name:** \_\_\_\_\_

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? \_\_\_\_\_



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**Day 5**

**Client Name:** \_\_\_\_\_

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? \_\_\_\_\_



**Diet, Exercise and Sleep Diary**  
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**Day 6**

**Client Name:** \_\_\_\_\_

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? \_\_\_\_\_



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**Day 7**

**Client Name:** \_\_\_\_\_

Date:			
Morning Meal Time:		Water (oz/cups) Source	
Snack		Additional Beverages	
Noon Meal Time:		Fats/Oils	
		Condiments (sugar/salt/spices, etc.)	
Snack			
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? \_\_\_\_\_





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**Day 8**

**Client Name:** \_\_\_\_\_

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? \_\_\_\_\_



**Diet, Exercise and Sleep Diary**  
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**Day 9**

**Client Name:** \_\_\_\_\_

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? \_\_\_\_\_



**Diet, Exercise and Sleep Diary**  
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**Day 10**

**Client Name:** \_\_\_\_\_

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? \_\_\_\_\_

