WEEK IN REVIEW

DATE		PATIENT NAME	

Did you have any of the following symptoms this week? (check all that apply)			
____ headache	____ weakness	____ fatigue	____ lightheadedness
____ cramps	____ hair loss	____ diarrhea	____ constipation
Other: _____			
Did you receive any medical care this week?			
____ No ____ Yes			
If yes, where and what for?			
What medications and/or supplements did you take this past week? Changes? Side effects?			
How many packages of Meal Replacement products did you eat?			
____ Mon ____ Tues ____ Wed ____ Thurs ____ Fri ____ Sat ____ Sun Total _____			
How many "lean and green"/grocery store meals did you eat?			
____ Mon ____ Tues ____ Wed ____ Thurs ____ Fri ____ Sat ____ Sun Total _____			
How many extra grocery store snacks if any?			
____ Mon ____ Tues ____ Wed ____ Thurs ____ Fri ____ Sat ____ Sun Total _____			
Did you eat out this week? If yes, where and what did you have?			
Did you have any problems adhering to the program? If yes, describe the situation?			
____ No ____ Yes			
How many days did you exercise this week? What type of activity? How many minutes?			
For the upcoming week, do you have any concerns or is there any information we should know?			

_____ _____

Patient Signature Staff Signature