

## WEEK IN REVIEW

DATE		PATIENT NAME	
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Did you have any of the following symptoms this week? (check all that apply)

<input type="checkbox"/> headache	<input type="checkbox"/> weakness	<input type="checkbox"/> fatigue	<input type="checkbox"/> lightheadedness
<input type="checkbox"/> cramps	<input type="checkbox"/> hair loss	<input type="checkbox"/> diarrhea	<input type="checkbox"/> 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