Name: _____
Date: / /
Day:

METABOLIC C.H.A.R.G.E

Sleep	Time	C.H.A.R.G.E
From: To: Quality Morning Energy Times awake		
Breakfast **Time**: Drink: Meds/Supps ☐		
Morning Snack **Time**: Drink: Meds/Supps ☐		
Lunch **Time**: Drink: Meds/Supps ☐		
Afternoon Snack **Time**: Drink: Meds/Supps ☐		
Dinner **Time**: Drink: Meds/Supps ☐		
Evening Snack **Time**: Drink: Meds/Supps ☐		
Any Significant Daily Activities		Record notable physical/mental feelings and timing C: yes/no? when? for what? H: Yes/no? when? A: predominate mood during different times of day R: how long? how well? times awake? Time for you? G: notable GI signs or symptoms? when? E: 1-10, rate through day? Quality?

Cravings **H**unger **A**ttitude/Mood **R**est/Sleep **G**ut/Digestion **E**nergy