Name: _____
Date: / /
Day:

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

Breakfast	Time	C.H.A.R.G.E
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 ☐		
Time | **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