JANAYA KARLOCI
Naturopath

Food, Symptom & Hydration Diary
7 Day Tracking

HOW TO COMPLETE THIS DIARY

Duration: Track for 7 consecutive days (1 full week)

IMPORTANT - Food Entry Instructions:

- **First time writing a food:** Include ALL details (type of bread, sauce, fillings)
  - Example: "Chicken avocado sandwich: wholegrain bread, mayo, grilled chicken breast, 1/2 avocado, lettuce"
- **If you eat same thing again:** Just write "as before" or "standard lunch"
  - This saves time while giving me the detail I need!

Key Tips:

- Fill out AS YOU GO (not at end of day)
- Be completely honest - this is for YOU
- Include everything you eat and drink
- Track water at each meal
- Set phone reminders if helpful

RATING SCALES REFERENCE

OCD Intensity (1-10): 1-3=Minimal, easy to redirect | 4-6=Moderate, some compulsions | 7-9=Significant, strong urges | 10=Overwhelming

Anxiety Level (1-10): 1-3=Calm, relaxed | 4-6=Noticeable, some physical symptoms | 7-9=High, significant symptoms | 10=Panic level

Energy Level (1-10): 1-3=Exhausted | 4-6=Low, getting through | 7-9=Good, productive | 10=Excellent

Dream Intensity (1-10): 1=No dreams or very calm | 3-4=Light dreams, easy | 5-6=Active dreams, some intensity | 7-8=Intense, vivid, active | 10=Feel like been in battle

Bristol Stool Scale: Type 1-2=Constipated | Type 3-4=NORMAL (goal) | Type 5-7=Diarrhea

💧 = 1 glass or 250mL of water

DAY 1 – DAILY TRACKER Date: _____

Last Night

Bed Time:

OCD Level at bed time (1-10)

Time to Fall Asleep:

Time Woke During the Night:

Upon Waking

Final Wake Time:

Dream Intensity (1-10):

Woke Sweating? Yes No

Upon Waking

Mood (1-10):

Energy (1-10):

OCD (1-10):

Physical symptoms: (circle) Chest tight / Heart aware / Tense neck/shoulders / Headache / Other: _____

FOOD, DRINK & SYMPTOMS LOG

Meal	Food	Drink	Symptoms 2 Hours after consuming
Breakfast Time _____			Anxiety/OCD ___/10
Lunch Time _____			Anxiety/OCD ___/10
Dinner Time_____			Anxiety/OCD ___/10
Snack 1 (if any) Time_____			Anxiety/OCD ___/10
Snack 2 (if any) Time_____		_	Anxiety/OCD ___/10

END OF DAY SUMMARY

Daily Water: 💧x___ = ____ ml

Total OCD hrs: ___

Panic Attacks: # ___ | Sev: M Mod S

Exercise: Type: _____ Dur: _____

Bowel Movement: Y N

Best moment: _____

Most challenging moment: _____

Notes/Observations: _____

DAY 2 – DAILY TRACKER

Last Night

Bed Time:

OCD Level at bed time (1-10)

Time to Fall Asleep:

Time Woke During the Night:

Upon Waking

Final Wake Time:

Dream Intensity (1-10):

Woke Sweating? Yes No

Upon Waking

Mood (1-10):

Energy (1-10):

OCD (1-10):

Physical symptoms: (circle) Chest tight / Heart aware / Tense neck/shoulders / Headache / Other: _____

FOOD, DRINK & SYMPTOMS LOG

Meal	Food	Drink	Symptoms 2 Hours after consuming
Breakfast Time _____			Anxiety/OCD ___/10
Lunch Time _____			Anxiety/OCD ___/10
Dinner Time_____			Anxiety/OCD ___/10
Snack 1 (if any) Time_____			Anxiety/OCD ___/10
Snack 2 (if any) Time_____		_	Anxiety/OCD ___/10

END OF DAY SUMMARY

Daily Water: 💧x___ = ____ ml

Total OCD hrs: ___

Panic Attacks: # ___ | Sev: M Mod S

Exercise: Type: _____ Dur: _____

Bowel Movement: Y N

Best moment: _____

Most challenging moment: _____

Notes/Observations: _____

DAY 3 – DAILY TRACKER

Last Night

Bed Time:

OCD Level at bed time (1-10)

Time to Fall Asleep:

Time Woke During the Night:

Upon Waking

Final Wake Time:

Dream Intensity (1-10):

Woke Sweating? Yes No

Upon Waking

Mood (1-10):

Energy (1-10):

OCD (1-10):

Physical symptoms: (circle) Chest tight / Heart aware / Tense neck/shoulders / Headache / Other: _____

FOOD, DRINK & SYMPTOMS LOG

Meal	Food	Drink	Symptoms 2 Hours after consuming
Breakfast Time _____			Anxiety/OCD ___/10
Lunch Time _____			Anxiety/OCD ___/10
Dinner Time_____			Anxiety/OCD ___/10
Snack 1 (if any) Time_____			Anxiety/OCD ___/10
Snack 2 (if any) Time_____		_	Anxiety/OCD ___/10

END OF DAY SUMMARY

Daily Water: 💧x___ = ____ ml

Total OCD hrs: ___

Panic Attacks: # ___ | Sev: M Mod S

Exercise: Type: _____ Dur: _____

Bowel Movement: Y N

Best moment: _____

Most challenging moment: _____

Notes/Observations: _____

DAY 4 – DAILY TRACKER

Last Night

Bed Time:

OCD Level at bed time (1-10)

Time to Fall Asleep:

Time Woke During the Night:

Upon Waking

Final Wake Time:

Dream Intensity (1-10):

Woke Sweating? Yes No

Upon Waking

Mood (1-10):

Energy (1-10):

OCD (1-10):

Physical symptoms: (circle) Chest tight / Heart aware / Tense neck/shoulders / Headache / Other: _____

FOOD, DRINK & SYMPTOMS LOG

Meal	Food	Drink	Symptoms 2 Hours after consuming
Breakfast Time _____			Anxiety/OCD ___/10
Lunch Time _____			Anxiety/OCD ___/10
Dinner Time_____			Anxiety/OCD ___/10
Snack 1 (if any) Time_____			Anxiety/OCD ___/10
Snack 2 (if any) Time_____		_	Anxiety/OCD ___/10

END OF DAY SUMMARY

Daily Water: 💧x___ = ____ ml

Total OCD hrs: ___

Panic Attacks: # ___ | Sev: M Mod S

Exercise: Type: _____ Dur: _____

Bowel Movement: Y N

Best moment: _____

Most challenging moment: _____

Notes/Observations: _____

DAY 5 – DAILY TRACKER

Last Night

Bed Time:

OCD Level at bed time (1-10)

Time to Fall Asleep:

Time Woke During the Night:

Upon Waking

Final Wake Time:

Dream Intensity (1-10):

Woke Sweating? Yes No

Upon Waking

Mood (1-10):

Energy (1-10):

OCD (1-10):

Physical symptoms: (circle) Chest tight / Heart aware / Tense neck/shoulders / Headache / Other: _____

FOOD, DRINK & SYMPTOMS LOG

Meal	Food	Drink	Symptoms 2 Hours after consuming
Breakfast Time _____			Anxiety/OCD ___/10
Lunch Time _____			Anxiety/OCD ___/10
Dinner Time_____			Anxiety/OCD ___/10
Snack 1 (if any) Time_____			Anxiety/OCD ___/10
Snack 2 (if any) Time_____		_	Anxiety/OCD ___/10

END OF DAY SUMMARY

Daily Water: 💧x___ = ____ ml

Total OCD hrs: ___

Panic Attacks: # ___ | Sev: M Mod S

Exercise: Type: _____ Dur: _____

Bowel Movement: Y N

Best moment: _____

Most challenging moment: _____

Notes/Observations: _____

DAY 6 – DAILY TRACKER

Last Night

Bed Time:

OCD Level at bed time (1-10)

Time to Fall Asleep:

Time Woke During the Night:

Upon Waking

Final Wake Time:

Dream Intensity (1-10):

Woke Sweating? Yes No

Upon Waking

Mood (1-10):

Energy (1-10):

OCD (1-10):

Physical symptoms: (circle) Chest tight / Heart aware / Tense neck/shoulders / Headache / Other: _____

FOOD, DRINK & SYMPTOMS LOG

Meal	Food	Drink	Symptoms 2 Hours after consuming
Breakfast Time _____			Anxiety/OCD ___/10
Lunch Time _____			Anxiety/OCD ___/10
Dinner Time_____			Anxiety/OCD ___/10
Snack 1 (if any) Time_____			Anxiety/OCD ___/10
Snack 2 (if any) Time_____		_	Anxiety/OCD ___/10

END OF DAY SUMMARY

Daily Water: 💧x___ = ____ ml

Total OCD hrs: ___

Panic Attacks: # ___ | Sev: M Mod S

Exercise: Type: _____ Dur: _____

Bowel Movement: Y N

Best moment: _____

Most challenging moment: _____

Notes/Observations: _____

DAY 7 – DAILY TRACKER

Last Night

Bed Time:

OCD Level at bed time (1-10)

Time to Fall Asleep:

Time Woke During the Night:

Upon Waking

Final Wake Time:

Dream Intensity (1-10):

Woke Sweating? Yes No

Upon Waking

Mood (1-10):

Energy (1-10):

OCD (1-10):

Physical symptoms: (circle) Chest tight / Heart aware / Tense neck/shoulders / Headache / Other: _____

FOOD, DRINK & SYMPTOMS LOG

Meal	Food	Drink	Symptoms 2 Hours after consuming
Breakfast Time _____			Anxiety/OCD ___/10
Lunch Time _____			Anxiety/OCD ___/10
Dinner Time_____			Anxiety/OCD ___/10
Snack 1 (if any) Time_____			Anxiety/OCD ___/10
Snack 2 (if any) Time_____		_	Anxiety/OCD ___/10

END OF DAY SUMMARY

Daily Water: 💧x___ = ____ ml

Total OCD hrs: ___

Panic Attacks: # ___ | Sev: M Mod S

Exercise: Type: _____ Dur: _____

Bowel Movement: Y N

Best moment: _____

Most challenging moment: _____

Notes/Observations: _____

AFTER 7 DAYS - WEEKLY PATTERNS

Foods that made me feel BETTER:

1.

2.

3.

Foods that made me feel WORSE:

1.

2.

3.

Times when OCD/anxiety is HIGHEST:

Morning Mid-morning Lunch Afternoon Evening Night

Times when I feel BEST:

Morning Mid-morning Lunch Afternoon Evening Night

Average daily water: _____ ml | Did water intake affect my symptoms? _____

Sleep/Dream observations: _____

_____

_____

Key insights I noticed:

1.

2.

3.

Questions for next appointment:

1.

2.

3.

Remember: You're doing great! This information helps us understand your patterns and create the best treatment plan for you. Bring this completed diary to your next appointment.