



## One Week IBS Journal

This is a simple journal that you can use to track one week of diet, physical symptoms, emotional state, and gastric events. Keeping a diary like this one will help you identify your personal “trigger foods” and begin to identify proactive behaviors that will help you minimize your IBS symptoms.

### How to use it.

1. Print the journal in landscape mode.
2. Each day of the week has its own page and is separated into three time-periods: Morning, Afternoon, and Evening. Just keep a register of your foods, gastric events (AKA “trips to the bathroom”), physical state, and emotional state.
3. After a week you may begin to see patterns that will help you make better decisions that will minimize your IBS symptoms.
4. Share the results with your doctor.

# Monday

date: \_\_\_\_/\_\_\_\_/\_\_\_\_

|               |                            |  |  |       |
|---------------|----------------------------|--|--|-------|
| morning       | This morning I ate...      |  | <input type="checkbox"/> Caffeine <input type="checkbox"/> Dairy<br><input type="checkbox"/> Grains <input type="checkbox"/> Alcohol | NOTES |
|               | In the bathroom...         |  | <input type="checkbox"/> Constipated<br><input type="checkbox"/> Diarrhea  | NOTES |
|               | Mentally, I'm feeling...   | CHECK ALL THAT APPLY<br><input type="checkbox"/> Really good! <input type="checkbox"/> Happy <input type="checkbox"/> Sad <input type="checkbox"/> Anxious <input type="checkbox"/> Depressed                    |  | NOTES |
|               | Physically, I'm feeling... | CHECK ALL THAT APPLY<br><input type="checkbox"/> Really good! <input type="checkbox"/> Cramping <input type="checkbox"/> Constipated <input type="checkbox"/> Bloating <input type="checkbox"/> Having my period |  | NOTES |
| afternoon     | This afternoon I ate...    |  | <input type="checkbox"/> Caffeine <input type="checkbox"/> Dairy<br><input type="checkbox"/> Grains <input type="checkbox"/> Alcohol | NOTES |
|               | In the bathroom...         |  | <input type="checkbox"/> Constipated<br><input type="checkbox"/> Diarrhea  | NOTES |
|               | Mentally, I'm feeling...   | CHECK ALL THAT APPLY<br><input type="checkbox"/> Really good! <input type="checkbox"/> Happy <input type="checkbox"/> Sad <input type="checkbox"/> Anxious <input type="checkbox"/> Depressed                    |  | NOTES |
|               | Physically, I'm feeling... | CHECK ALL THAT APPLY<br><input type="checkbox"/> Really good! <input type="checkbox"/> Cramping <input type="checkbox"/> Constipated <input type="checkbox"/> Bloating <input type="checkbox"/> Having my period |  | NOTES |
| evening/night | This evening I ate...      |  | <input type="checkbox"/> Caffeine <input type="checkbox"/> Dairy<br><input type="checkbox"/> Grains <input type="checkbox"/> Alcohol | NOTES |
|               | In the bathroom...         |  | <input type="checkbox"/> Constipated<br><input type="checkbox"/> Diarrhea  | NOTES |
|               | Mentally, I'm feeling...   | CHECK ALL THAT APPLY<br><input type="checkbox"/> Really good! <input type="checkbox"/> Happy <input type="checkbox"/> Sad <input type="checkbox"/> Anxious <input type="checkbox"/> Depressed                    |  | NOTES |
|               | Physically, I'm feeling... | CHECK ALL THAT APPLY<br><input type="checkbox"/> Really good! <input type="checkbox"/> Cramping <input type="checkbox"/> Constipated <input type="checkbox"/> Bloating <input type="checkbox"/> Having my period |  | NOTES |

# Tuesday

date: \_\_\_\_/\_\_\_\_/\_\_\_\_

|               |                            |  |  |       |
|---------------|----------------------------|--|--|-------|
| morning       | This morning I ate...      |  | <input type="checkbox"/> Caffeine <input type="checkbox"/> Dairy<br><input type="checkbox"/> Grains <input type="checkbox"/> Alcohol | NOTES |
|               | In the bathroom...         |  | <input type="checkbox"/> Constipated<br><input type="checkbox"/> Diarrhea  | NOTES |
|               | Mentally, I'm feeling...   | CHECK ALL THAT APPLY<br><input type="checkbox"/> Really good! <input type="checkbox"/> Happy <input type="checkbox"/> Sad <input type="checkbox"/> Anxious <input type="checkbox"/> Depressed                    |  | NOTES |
|               | Physically, I'm feeling... | CHECK ALL THAT APPLY<br><input type="checkbox"/> Really good! <input type="checkbox"/> Cramping <input type="checkbox"/> Constipated <input type="checkbox"/> Bloating <input type="checkbox"/> Having my period |  | NOTES |
| afternoon     | This afternoon I ate...    |  | <input type="checkbox"/> Caffeine <input type="checkbox"/> Dairy<br><input type="checkbox"/> Grains <input type="checkbox"/> Alcohol | NOTES |
|               | In the bathroom...         |  | <input type="checkbox"/> Constipated<br><input type="checkbox"/> Diarrhea  | NOTES |
|               | Mentally, I'm feeling...   | CHECK ALL THAT APPLY<br><input type="checkbox"/> Really good! <input type="checkbox"/> Happy <input type="checkbox"/> Sad <input type="checkbox"/> Anxious <input type="checkbox"/> Depressed                    |  | NOTES |
|               | Physically, I'm feeling... | CHECK ALL THAT APPLY<br><input type="checkbox"/> Really good! <input type="checkbox"/> Cramping <input type="checkbox"/> Constipated <input type="checkbox"/> Bloating <input type="checkbox"/> Having my period |  | NOTES |
| evening/night | This evening I ate...      |  | <input type="checkbox"/> Caffeine <input type="checkbox"/> Dairy<br><input type="checkbox"/> Grains <input type="checkbox"/> Alcohol | NOTES |
|               | In the bathroom...         |  | <input type="checkbox"/> Constipated<br><input type="checkbox"/> Diarrhea  | NOTES |
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|               | Physically, I'm feeling... | CHECK ALL THAT APPLY<br><input type="checkbox"/> Really good! <input type="checkbox"/> Cramping <input type="checkbox"/> Constipated <input type="checkbox"/> Bloating <input type="checkbox"/> Having my period |  | NOTES |

# Wednesday

date: \_\_\_\_/\_\_\_\_/\_\_\_\_

|               |                            |  |       |
|---------------|----------------------------|--|-------|
| morning       | This morning I ate...      | <input type="checkbox"/> Caffeine <input type="checkbox"/> Dairy<br><input type="checkbox"/> Grains <input type="checkbox"/> Alcohol   | NOTES |
|               | In the bathroom...         | <input type="checkbox"/> Constipated<br><input type="checkbox"/> Diarrhea  | NOTES |
|               | Mentally, I'm feeling...   | CHECK ALL THAT APPLY<br><input type="checkbox"/> Really good! <input type="checkbox"/> Happy <input type="checkbox"/> Sad <input type="checkbox"/> Anxious <input type="checkbox"/> Depressed                    | NOTES |
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| afternoon     | This afternoon I ate...    | <input type="checkbox"/> Caffeine <input type="checkbox"/> Dairy<br><input type="checkbox"/> Grains <input type="checkbox"/> Alcohol   | NOTES |
|               | In the bathroom...         | <input type="checkbox"/> Constipated<br><input type="checkbox"/> Diarrhea  | NOTES |
|               | Mentally, I'm feeling...   | CHECK ALL THAT APPLY<br><input type="checkbox"/> Really good! <input type="checkbox"/> Happy <input type="checkbox"/> Sad <input type="checkbox"/> Anxious <input type="checkbox"/> Depressed                    | NOTES |
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| evening/night | This evening I ate...      | <input type="checkbox"/> Caffeine <input type="checkbox"/> Dairy<br><input type="checkbox"/> Grains <input type="checkbox"/> Alcohol   | NOTES |
|               | In the bathroom...         | <input type="checkbox"/> Constipated<br><input type="checkbox"/> Diarrhea  | NOTES |
|               | Mentally, I'm feeling...   | CHECK ALL THAT APPLY<br><input type="checkbox"/> Really good! <input type="checkbox"/> Happy <input type="checkbox"/> Sad <input type="checkbox"/> Anxious <input type="checkbox"/> Depressed                    | NOTES |
|               | Physically, I'm feeling... | CHECK ALL THAT APPLY<br><input type="checkbox"/> Really good! <input type="checkbox"/> Cramping <input type="checkbox"/> Constipated <input type="checkbox"/> Bloating <input type="checkbox"/> Having my period | NOTES |

# Thursday

date: \_\_\_\_/\_\_\_\_/\_\_\_\_

|               |                            |  |  |       |
|---------------|----------------------------|--|--|-------|
| morning       | This morning I ate...      |  | <input type="checkbox"/> Caffeine <input type="checkbox"/> Dairy<br><input type="checkbox"/> Grains <input type="checkbox"/> Alcohol | NOTES |
|               | In the bathroom...         |  | <input type="checkbox"/> Constipated<br><input type="checkbox"/> Diarrhea  | NOTES |
|               | Mentally, I'm feeling...   | CHECK ALL THAT APPLY<br><input type="checkbox"/> Really good! <input type="checkbox"/> Happy <input type="checkbox"/> Sad <input type="checkbox"/> Anxious <input type="checkbox"/> Depressed                    |  | NOTES |
|               | Physically, I'm feeling... | CHECK ALL THAT APPLY<br><input type="checkbox"/> Really good! <input type="checkbox"/> Cramping <input type="checkbox"/> Constipated <input type="checkbox"/> Bloating <input type="checkbox"/> Having my period |  | NOTES |
| afternoon     | This afternoon I ate...    |  | <input type="checkbox"/> Caffeine <input type="checkbox"/> Dairy<br><input type="checkbox"/> Grains <input type="checkbox"/> Alcohol | NOTES |
|               | In the bathroom...         |  | <input type="checkbox"/> Constipated<br><input type="checkbox"/> Diarrhea  | NOTES |
|               | Mentally, I'm feeling...   | CHECK ALL THAT APPLY<br><input type="checkbox"/> Really good! <input type="checkbox"/> Happy <input type="checkbox"/> Sad <input type="checkbox"/> Anxious <input type="checkbox"/> Depressed                    |  | NOTES |
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| evening/night | This evening I ate...      |  | <input type="checkbox"/> Caffeine <input type="checkbox"/> Dairy<br><input type="checkbox"/> Grains <input type="checkbox"/> Alcohol | NOTES |
|               | In the bathroom...         |  | <input type="checkbox"/> Constipated<br><input type="checkbox"/> Diarrhea  | NOTES |
|               | Mentally, I'm feeling...   | CHECK ALL THAT APPLY<br><input type="checkbox"/> Really good! <input type="checkbox"/> Happy <input type="checkbox"/> Sad <input type="checkbox"/> Anxious <input type="checkbox"/> Depressed                    |  | NOTES |
|               | Physically, I'm feeling... | CHECK ALL THAT APPLY<br><input type="checkbox"/> Really good! <input type="checkbox"/> Cramping <input type="checkbox"/> Constipated <input type="checkbox"/> Bloating <input type="checkbox"/> Having my period |  | NOTES |

Friday

date: \_\_\_\_/\_\_\_\_/\_\_\_\_

|               |                            |  |       |
|---------------|----------------------------|--|-------|
| morning       | This morning I ate...      | <input type="checkbox"/> Caffeine <input type="checkbox"/> Dairy<br><input type="checkbox"/> Grains <input type="checkbox"/> Alcohol   | NOTES |
|               | In the bathroom...         | <input type="checkbox"/> Constipated<br><input type="checkbox"/> Diarrhea  | NOTES |
|               | Mentally, I'm feeling...   | CHECK ALL THAT APPLY<br><input type="checkbox"/> Really good! <input type="checkbox"/> Happy <input type="checkbox"/> Sad <input type="checkbox"/> Anxious <input type="checkbox"/> Depressed                    | NOTES |
|               | Physically, I'm feeling... | CHECK ALL THAT APPLY<br><input type="checkbox"/> Really good! <input type="checkbox"/> Cramping <input type="checkbox"/> Constipated <input type="checkbox"/> Bloating <input type="checkbox"/> Having my period | NOTES |
| afternoon     | This afternoon I ate...    | <input type="checkbox"/> Caffeine <input type="checkbox"/> Dairy<br><input type="checkbox"/> Grains <input type="checkbox"/> Alcohol   | NOTES |
|               | In the bathroom...         | <input type="checkbox"/> Constipated<br><input type="checkbox"/> Diarrhea  | NOTES |
|               | Mentally, I'm feeling...   | CHECK ALL THAT APPLY<br><input type="checkbox"/> Really good! <input type="checkbox"/> Happy <input type="checkbox"/> Sad <input type="checkbox"/> Anxious <input type="checkbox"/> Depressed                    | NOTES |
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| evening/night | This evening I ate...      | <input type="checkbox"/> Caffeine <input type="checkbox"/> Dairy<br><input type="checkbox"/> Grains <input type="checkbox"/> Alcohol   | NOTES |
|               | In the bathroom...         | <input type="checkbox"/> Constipated<br><input type="checkbox"/> Diarrhea  | NOTES |
|               | Mentally, I'm feeling...   | CHECK ALL THAT APPLY<br><input type="checkbox"/> Really good! <input type="checkbox"/> Happy <input type="checkbox"/> Sad <input type="checkbox"/> Anxious <input type="checkbox"/> Depressed                    | NOTES |
|               | Physically, I'm feeling... | CHECK ALL THAT APPLY<br><input type="checkbox"/> Really good! <input type="checkbox"/> Cramping <input type="checkbox"/> Constipated <input type="checkbox"/> Bloating <input type="checkbox"/> Having my period | NOTES |

# Saturday

date: \_\_\_\_/\_\_\_\_/\_\_\_\_

|               |                            |  |  |       |
|---------------|----------------------------|--|--|-------|
| morning       | This morning I ate...      |  | <input type="checkbox"/> Caffeine <input type="checkbox"/> Dairy<br><input type="checkbox"/> Grains <input type="checkbox"/> Alcohol | NOTES |
|               | In the bathroom...         |  | <input type="checkbox"/> Constipated<br><input type="checkbox"/> Diarrhea  | NOTES |
|               | Mentally, I'm feeling...   | CHECK ALL THAT APPLY<br><input type="checkbox"/> Really good! <input type="checkbox"/> Happy <input type="checkbox"/> Sad <input type="checkbox"/> Anxious <input type="checkbox"/> Depressed                    |  | NOTES |
|               | Physically, I'm feeling... | CHECK ALL THAT APPLY<br><input type="checkbox"/> Really good! <input type="checkbox"/> Cramping <input type="checkbox"/> Constipated <input type="checkbox"/> Bloating <input type="checkbox"/> Having my period |  | NOTES |
| afternoon     | This afternoon I ate...    |  | <input type="checkbox"/> Caffeine <input type="checkbox"/> Dairy<br><input type="checkbox"/> Grains <input type="checkbox"/> Alcohol | NOTES |
|               | In the bathroom...         |  | <input type="checkbox"/> Constipated<br><input type="checkbox"/> Diarrhea  | NOTES |
|               | Mentally, I'm feeling...   | CHECK ALL THAT APPLY<br><input type="checkbox"/> Really good! <input type="checkbox"/> Happy <input type="checkbox"/> Sad <input type="checkbox"/> Anxious <input type="checkbox"/> Depressed                    |  | NOTES |
|               | Physically, I'm feeling... | CHECK ALL THAT APPLY<br><input type="checkbox"/> Really good! <input type="checkbox"/> Cramping <input type="checkbox"/> Constipated <input type="checkbox"/> Bloating <input type="checkbox"/> Having my period |  | NOTES |
| evening/night | This evening I ate...      |  | <input type="checkbox"/> Caffeine <input type="checkbox"/> Dairy<br><input type="checkbox"/> Grains <input type="checkbox"/> Alcohol | NOTES |
|               | In the bathroom...         |  | <input type="checkbox"/> Constipated<br><input type="checkbox"/> Diarrhea  | NOTES |
|               | Mentally, I'm feeling...   | CHECK ALL THAT APPLY<br><input type="checkbox"/> Really good! <input type="checkbox"/> Happy <input type="checkbox"/> Sad <input type="checkbox"/> Anxious <input type="checkbox"/> Depressed                    |  | NOTES |
|               | Physically, I'm feeling... | CHECK ALL THAT APPLY<br><input type="checkbox"/> Really good! <input type="checkbox"/> Cramping <input type="checkbox"/> Constipated <input type="checkbox"/> Bloating <input type="checkbox"/> Having my period |  | NOTES |

# Sunday

date: \_\_\_\_/\_\_\_\_/\_\_\_\_

|               |                            |  |       |
|---------------|----------------------------|--|-------|
| morning       | This morning I ate...      | <input type="checkbox"/> Caffeine <input type="checkbox"/> Dairy<br><input type="checkbox"/> Grains <input type="checkbox"/> Alcohol   | NOTES |
|               | In the bathroom...         | <input type="checkbox"/> Constipated<br><input type="checkbox"/> Diarrhea  | NOTES |
|               | Mentally, I'm feeling...   | CHECK ALL THAT APPLY<br><input type="checkbox"/> Really good! <input type="checkbox"/> Happy <input type="checkbox"/> Sad <input type="checkbox"/> Anxious <input type="checkbox"/> Depressed                    | NOTES |
|               | Physically, I'm feeling... | CHECK ALL THAT APPLY<br><input type="checkbox"/> Really good! <input type="checkbox"/> Cramping <input type="checkbox"/> Constipated <input type="checkbox"/> Bloating <input type="checkbox"/> Having my period | NOTES |
| afternoon     | This afternoon I ate...    | <input type="checkbox"/> Caffeine <input type="checkbox"/> Dairy<br><input type="checkbox"/> Grains <input type="checkbox"/> Alcohol   | NOTES |
|               | In the bathroom...         | <input type="checkbox"/> Constipated<br><input type="checkbox"/> Diarrhea  | NOTES |
|               | Mentally, I'm feeling...   | CHECK ALL THAT APPLY<br><input type="checkbox"/> Really good! <input type="checkbox"/> Happy <input type="checkbox"/> Sad <input type="checkbox"/> Anxious <input type="checkbox"/> Depressed                    | NOTES |
|               | Physically, I'm feeling... | CHECK ALL THAT APPLY<br><input type="checkbox"/> Really good! <input type="checkbox"/> Cramping <input type="checkbox"/> Constipated <input type="checkbox"/> Bloating <input type="checkbox"/> Having my period | NOTES |
| evening/night | This evening I ate...      | <input type="checkbox"/> Caffeine <input type="checkbox"/> Dairy<br><input type="checkbox"/> Grains <input type="checkbox"/> Alcohol   | NOTES |
|               | In the bathroom...         | <input type="checkbox"/> Constipated<br><input type="checkbox"/> Diarrhea  | NOTES |
|               | Mentally, I'm feeling...   | CHECK ALL THAT APPLY<br><input type="checkbox"/> Really good! <input type="checkbox"/> Happy <input type="checkbox"/> Sad <input type="checkbox"/> Anxious <input type="checkbox"/> Depressed                    | NOTES |
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