Food Reintroduction Protocol

On the last day of your Reset please rate the following symptoms which will help to track the effect of reintroduction of certain food groups (1=low, 10=high)

Overall Energy:
Frequency of Bowel Movements: _____ times per day _____ times per week
Quality of Sleep:
Irritability:
Anxiety/Depression:
Bloating:
Gassiness:
Stomach Cramps:
Headaches:
Sugar Cravings:
Salt Cravings:

After you have reintroduced gluten, please rate the following symptoms, noting any changes from when you first finished the Reset (1=low, 10=high)

Frequency of Bowel Movements: _____ times per day _____ times per week
Quality of Sleep:
Irritability:
Anxiety/Depression:
Bloating:
Gassiness:
Stomach Cramps:
Headaches:
Sugar Cravings:
Salt Cravings:

After you have reintroduced dairy, please rate the following symptoms, noting any changes from when you first finished the Reset (1=low, 10=high)

Frequency of Bowel Movements: _____ times per day _____ times per week
Quality of Sleep:
Irritability:
Anxiety/Depression:
Bloating:
Gassiness:
Stomach Cramps:
Headaches:
Sugar Cravings:
Salt Cravings: