WORKSHEET 1 / WEEKLY FOOD PLANNING

Make room for nourishment.

Week of: _____ Plan only what helps. Add meals and snacks to meet your needs; this is not a restriction checklist.

Day	Breakfast	Lunch	Dinner	Other food / snacks
Mon				
Tue				
Wed				
Thu				
Fri				
Sat				
Sun				

Foods I already have / meals I can repeat: _____

My clinician or dietitian’s individualized nutrition notes: _____

WORKSHEET 2 / GROCERY & PREPARATION

Shop with a simple plan.

Check the pantry, choose quantities, and allow for trimming and draining. Keep raw proteins and prepared foods within safe storage windows.

Produce	Protein foods	Dairy / alternatives	Grains / pantry

Preparation plan

What I can cook or portion ahead: _____

What needs freezing: _____

Which dinner becomes tomorrow’s lunch: _____

One convenient backup meal: _____

Refrigerate perishables within 2 hours (1 hour above 90°F); keep at 40°F or below. Most cooked leftovers: 3-4 days or freeze. Reheat to 165°F. Sources S23-S24 in the handbook.

WORKSHEET 3 / SEVEN-DAY SLEEP NOTES

Look for sleep patterns.

Record for one or two weeks and discuss patterns with your clinician. This worksheet does not diagnose insomnia or sleep apnea.

Day	Bed / wake time	Awakenings / quality	Last meal / caffeine	Reflux / nausea	Daytime sleepiness
Mon					
Tue					
Wed					
Thu					
Fri					
Sat					
Sun					

Medication changes / injection day, if relevant: _____

Snoring, gasping, or other concerns to discuss: _____

Do not change medication timing or stop PAP treatment based only on these notes.

WORKSHEET 4 / SYMPTOM & COMFORT NOTES

A useful record for your visit.

Brief notes can help a clinician understand timing and impact. Do not wait to complete this sheet if urgent symptoms occur.

Date / time	Symptom & severity	Food / fluids / context	What helped or changed	Effect on daily life

Call 911 for an emergency. Severe/persistent abdominal pain, repeated vomiting, or inability to keep fluids down needs prompt assessment. This sheet is not monitored.

WORKSHEET 5 / NOURISHMENT & MOVEMENT

Track a steady rhythm.

Agree on personal targets with your clinician or dietitian. Do not use a generic target if you have a prescribed restriction.

My personal protein plan: _____ Fluid plan: _____

My appropriate activity starting point: _____

Day	Eating opportunities / protein foods	Fluids / tolerance	Movement / strength / energy
Mon			
Tue			
Wed			
Thu			
Fri			
Sat			
Sun			

One thing that became easier: _____

One adjustment to discuss: _____

WORKSHEET 6 / PREPARE FOR YOUR VISIT

Bring the questions that matter.

Appointment date: _____ Keep this sheet privately; share only through your verified clinical channel.

My main question or goal

Changes in food, fluids, sleep, or daily function

Symptoms: when they started, frequency, and impact

Medication / supplement list or recent changes

Practical barriers: schedule, cost, food access, or mobility

The next step agreed with my clinician

Clinical contact / follow-up date: _____

For urgent symptoms, seek appropriate care rather than waiting for the appointment.