

THE GUT HEALTH MANUAL

Companion Trackers

Twenty-two sheets to print or fill in on screen, for the problems and habits in the manual. Most take under a minute a day: you circle, tick and plot, and the page turns into a chart you can read and show your doctor.

Start

Sheets 01, 02 and 05 give you a baseline in the first week, whatever your problem.

Track

Add the one sheet that matches your chapter. One tracker at a time is plenty.

Review

Use sheet 06 after two weeks, and take sheet 07 to your appointment.

EVERYDAY
Use with any chapter

- 01 Stool Form and Colour Guide
- 02 Bowel Movement Log
- 03 Month at a Glance
- 04 Food and Symptom Timeline
- 05 Belly Map and Symptom Snapshot
- 06 Two-Week Review
- 07 Appointment Summary

PROBLEMS
Chapters 2 to 8

- 08 Bloating Tracker
- 09 Constipation Tracker
- 10 IBS Symptom Tracker
- 11 Mood and Gut Tracker
- 12 Energy and Cravings Tracker
- 13 Reflux Tracker
- 14 Antibiotic Recovery Tracker

FOUNDATIONS
Chapters 9 to 16

- 15 30 Plants a Week
- 16 Fermented Foods Tracker
- 17 Food Swaps Tracker
- 18 Movement Tracker
- 19 Sleep and Stress Diary
- 20 Medicines and Gut Record
- 21 Time Outdoors Tracker
- 22 Mind-Gut Practice Tracker

REFERENCE CARD · KEEP IT WITH YOUR LOG

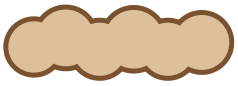
Stool Form and Colour Guide

Match what you see to a number from 1 to 7. Every tracker in this set uses the same numbers, so one glance is enough.



SHEET 01

THE SEVEN STOOL FORMS (BRISTOL SCALE TYPES 1 TO 7)

1		**Separate hard lumps** Like nuts. Hard to pass.	HARD
2		**Lumpy sausage** Sausage-shaped but lumpy.	HARD
3		**Cracked sausage** A sausage with cracks on the surface.	COMFORTABLE
4		**Smooth and soft** Like a smooth, soft sausage or snake.	COMFORTABLE
5		**Soft blobs** Soft pieces with clear-cut edges. Easy to pass.	LOOSE
6		**Mushy** Fluffy pieces with ragged edges.	LOOSE
7		**Watery** No solid pieces. Entirely liquid.	LOOSE

Types 3 and 4 are the easiest to pass. A single odd day means little; the pattern over two to four weeks is what your doctor will ask about.

Colour

Brown
The usual range, light to dark.

Green
Often leafy vegetables, food colouring, iron, or food passing quickly.

Pale or clay
If it lasts more than a day or two, see your doctor.

Yellow, greasy, floating
If it keeps happening, mention it to your doctor.

Red
Beetroot can do this. Otherwise treat it as blood and get medical advice.

Black and tarry
Iron and bismuth can darken stool, but black, sticky stool needs urgent advice.

What to write in the log

Time
Write the clock time. Timing after meals is one of the most useful clues.

Urgency
0 no hurry · 1 soon · 2 had to hurry · 3 could not wait

Straining
0 none · 1 a little · 2 a lot · 3 could not pass it

Emptied
Did it feel complete? Y or N

Pain
0 none · 1 mild · 2 moderate · 3 severe. Note if going eased it.

Blood or mucus
Tick it and tell your doctor. Do not wait for the tracker to finish.

! **See a doctor before relying on a tracker** if you have blood in the stool or black, tarry stool, unexplained weight loss, symptoms that wake you at night, persistent vomiting, trouble swallowing, fever with pain, or a new and lasting change in bowel habit. Heavy bleeding, collapse or sudden severe pain is an emergency.

ONE LINE PER VISIT · ONE SHEET PER WEEK

Bowel Movement Log

One line each time you go. Circle the numbers; write only the time and anything that came just before. Days with no movement count too: leave the day blank and note it in the tally.

SHEET 02

Name _____ **Week starting** _____



1 Separate hard lumps · 2 Lumpy sausage — HARD · SLOW



3 Cracked sausage · 4 Smooth and soft — COMFORTABLE



5 Soft blobs · 6 Mushy · 7 Watery — LOOSE · FAST

DAY	TIME	STOOL TYPE CIRCLE ONE	URGENCY	STRAINING	EMPTIED?	PAIN	BLOOD MUCUS	WHAT CAME BEFORE: MEAL, DRINK, STRESS, MEDICINE
		1 2 3 4 5 6 7	0 1 2 3	0 1 2 3	Y N	0 1 2 3	○	
		1 2 3 4 5 6 7	0 1 2 3	0 1 2 3	Y N	0 1 2 3	○	
		1 2 3 4 5 6 7	0 1 2 3	0 1 2 3	Y N	0 1 2 3	○	
		1 2 3 4 5 6 7	0 1 2 3	0 1 2 3	Y N	0 1 2 3	○	
		1 2 3 4 5 6 7	0 1 2 3	0 1 2 3	Y N	0 1 2 3	○	
		1 2 3 4 5 6 7	0 1 2 3	0 1 2 3	Y N	0 1 2 3	○	
		1 2 3 4 5 6 7	0 1 2 3	0 1 2 3	Y N	0 1 2 3	○	
		1 2 3 4 5 6 7	0 1 2 3	0 1 2 3	Y N	0 1 2 3	○	
		1 2 3 4 5 6 7	0 1 2 3	0 1 2 3	Y N	0 1 2 3	○	
		1 2 3 4 5 6 7	0 1 2 3	0 1 2 3	Y N	0 1 2 3	○	
		1 2 3 4 5 6 7	0 1 2 3	0 1 2 3	Y N	0 1 2 3	○	
		1 2 3 4 5 6 7	0 1 2 3	0 1 2 3	Y N	0 1 2 3	○	
		1 2 3 4 5 6 7	0 1 2 3	0 1 2 3	Y N	0 1 2 3	○	
		1 2 3 4 5 6 7	0 1 2 3	0 1 2 3	Y N	0 1 2 3	○	
		1 2 3 4 5 6 7	0 1 2 3	0 1 2 3	Y N	0 1 2 3	○	
		1 2 3 4 5 6 7	0 1 2 3	0 1 2 3	Y N	0 1 2 3	○	
		1 2 3 4 5 6 7	0 1 2 3	0 1 2 3	Y N	0 1 2 3	○	
		1 2 3 4 5 6 7	0 1 2 3	0 1 2 3	Y N	0 1 2 3	○	
		1 2 3 4 5 6 7	0 1 2 3	0 1 2 3	Y N	0 1 2 3	○	
		1 2 3 4 5 6 7	0 1 2 3	0 1 2 3	Y N	0 1 2 3	○	
		1 2 3 4 5 6 7	0 1 2 3	0 1 2 3	Y N	0 1 2 3	○	
		1 2 3 4 5 6 7	0 1 2 3	0 1 2 3	Y N	0 1 2 3	○	

Add up the week

Movements this week _____ Days with none _____ Most common type _____ Days of type 1 or 2 _____ Days of type 6 or 7 _____

Laxative, fibre product or remedy used (name, dose, days) _____

! **No movement for three days, or hard stools that do not ease?** Ask a pharmacist. Blood, black stool, or a bowel habit that has changed for more than a few weeks needs a doctor, whatever the log shows.

31 DAYS ON ONE PAGE

Month at a Glance

Thirty seconds each evening. After a month the page becomes a chart: stool form across the top, symptoms and likely causes lined up underneath, day by day.



SHEET 03

Name _____ **Month** _____

DAY	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
STOOL TYPE: ONE DOT FOR EVERY MOVEMENT, ON THE LINE THAT MATCHES																															
7 Watery																															
6 Mushy																															
5 Soft blobs																															
4 Smooth, soft																															
3 Cracked sausage																															
2 Lumpy sausage																															
1 Hard lumps																															
Movements how many																															
SYMPTOMS: SHADE A CORNER FOR MILD, HALF FOR MODERATE, THE WHOLE BOX FOR SEVERE (ON SCREEN, TYPE 1, 2 OR 3)																															
Bloating																															
Pain or cramps																															
Urgency																															
Straining																															
Heartburn																															
Nausea																															
Low mood or worry																															
TICK THE DAYS IT APPLIED																															
Slept badly	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
High stress	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Period	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Alcohol	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Ate late	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Away from home	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Laxative or remedy	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Medicine changed	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Moved 20 min+	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○

What the month shows

Days with no movement _____ Days in the green band _____

Days of type 1 or 2 _____ Days of type 6 or 7 _____

Look down the columns on your worst days. What keeps turning up with them?

_____

_____

Rows of your own

Two rows are blank. Use them for one thing you suspect: a food, a supplement, a shift pattern. Tick the days and see whether it lines up.

! **See a doctor before relying on a tracker** if you have blood in the stool or black, tarry stool, unexplained weight loss, symptoms that wake you at night, persistent vomiting, trouble swallowing, fever with pain, or a new and lasting change in bowel habit. Heavy bleeding, collapse or sudden severe pain is an emergency.

THREE DAYS PER SHEET · PRINT AS MANY AS YOU NEED

Food and Symptom Timeline

Each day is a clock from 5 am to 3 am. Write food where you ate it and symptoms where they started. The gap between the two is the clue a list of meals never shows.



SHEET 04

Name _____

Symptoms B bloating · P pain · H heartburn · N nausea · U urgency · W wind, each with 1 mild, 2 moderate, 3 severe (so "B2")

Also M medicine or supplement · E exercise · S stressful moment · Z nap

Day and date _____ Woke _____ Bed _____ Slept (hours) _____ Glasses of fluid _____

CLOCK TIME	5	6	7	8	9	10	11	noon	1	2	3	4	5	6	7	8	9	10	11	12	1	2
Ate and drank write it at the time																						
Symptoms letter + 1 to 3																						
Toilet type 1-7																						
Also M E S Z																						

Worst symptom today _____ How bad, 0 to 10 _____ Stress, 0 to 10 _____

Day and date _____ Woke _____ Bed _____ Slept (hours) _____ Glasses of fluid _____

CLOCK TIME	5	6	7	8	9	10	11	noon	1	2	3	4	5	6	7	8	9	10	11	12	1	2
Ate and drank write it at the time																						
Symptoms letter + 1 to 3																						
Toilet type 1-7																						
Also M E S Z																						

Worst symptom today _____ How bad, 0 to 10 _____ Stress, 0 to 10 _____

Day and date _____ Woke _____ Bed _____ Slept (hours) _____ Glasses of fluid _____

CLOCK TIME	5	6	7	8	9	10	11	noon	1	2	3	4	5	6	7	8	9	10	11	12	1	2
Ate and drank write it at the time																						
Symptoms letter + 1 to 3																						
Toilet type 1-7																						
Also M E S Z																						

Worst symptom today _____ How bad, 0 to 10 _____ Stress, 0 to 10 _____

Timing is the point. Gut symptoms can follow a meal by minutes or by many hours, so a food diary without clock times misleads. Do not cut out a food on the strength of one bad day; look for the same gap turning up three times.

FILL IN ONCE NOW · AGAIN IN FOUR WEEKS

Belly Map and Symptom Snapshot

A picture of where you are starting from. Where a pain sits, and when it comes, narrows the possibilities faster than any score.

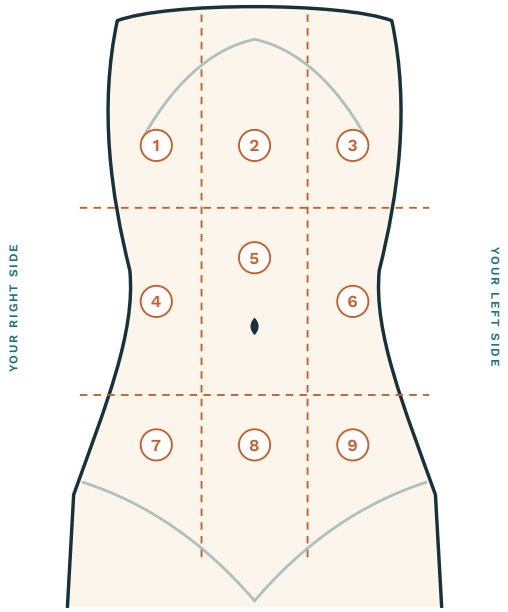


SHEET 05

Name _____ **Date** _____ **Date of repeat** _____

Where do you feel it?

Shade the areas. Use a second colour, or crosses, for where it spreads to.



1 Under the right ribs
2 Upper middle
3 Under the left ribs
4 Right side
5 Around the navel
6 Left side
7 Lower right
8 Lower middle
9 Lower left

IN THE LAST TWO WEEKS	NEVER	SOME DAYS	MOST DAYS	EVERY DAY
Bloating or swelling	○	○	○	○
Tummy pain or cramps	○	○	○	○
Wind	○	○	○	○
Constipation	○	○	○	○
Loose stools	○	○	○	○
Urgency	○	○	○	○
Heartburn or acid taste	○	○	○	○
Nausea	○	○	○	○
Feeling full early	○	○	○	○
Tiredness after meals	○	○	○	○
Low mood or worry	○	○	○	○
Other:	○	○	○	○

When is it worst?

☐ On waking ☐ After meals ☐ Late afternoon ☐ Evening
☐ In the night ☐ Around my period ☐ When stressed
☐ After poor sleep ☐ No pattern yet

How much do gut symptoms get in the way of...

Circle a number today. In four weeks, mark the same scales with a square and compare.

Sleep	not at all	0	1	2	3	4	5	6	7	8	9	10	completely
Eating what I like	not at all	0	1	2	3	4	5	6	7	8	9	10	completely
Work or daily tasks	not at all	0	1	2	3	4	5	6	7	8	9	10	completely
Going out	not at all	0	1	2	3	4	5	6	7	8	9	10	completely

In one sentence

The symptom that bothers me most is

_____

_____

It started

_____

What I most want to be able to do again

_____

_____

! **See a doctor before relying on a tracker** if you have blood in the stool or black, tarry stool, unexplained weight loss, symptoms that wake you at night, persistent vomiting, trouble swallowing, fever with pain, or a new and lasting change in bowel habit. Heavy bleeding, collapse or sudden severe pain is an emergency.

AFTER ANY 14-DAY TRACKER

Two-Week Review

Turn fourteen days of dots into one decision. Compare your best days with your worst, then choose a single thing to keep, one to test and one to ask about.



SHEET 06

Name _____ **Tracker reviewed** _____ **Dates** _____

The numbers

Average score, days 1 to 7 _____ days 8 to 14 _____

Movements, week 1 _____ week 2 _____

Most common stool type, week 1 _____ week 2 _____

Days I kept to my chosen step _____ out of 14

Read this first

Two weeks can show a pattern. It cannot prove a cause. A factor that appears on most of your worst days and few of your best ones is worth one careful test, changing one thing at a time. A factor that appears on both is probably not the answer.

GO THROUGH YOUR TRACKER AND PUT A TALLY MARK EACH TIME	ON MY 4 BEST DAYS	ON MY 4 WORST DAYS
Slept well		
Slept badly		
Moved for 20 minutes or more		
Ate at regular times		
Ate late or in a rush		
High-stress day		
Alcohol		
More fibre or plants than usual		
A food I suspect:		
Medicine or supplement change		
Period		
Away from home		

Keep

What clearly helped, and I will carry on doing

_____

_____

_____

Test next

The one change I will try for the next two weeks

_____

_____

_____

Ask

What I cannot explain and will raise with my doctor or pharmacist

_____

_____

_____

No better after two to four weeks of steady effort? That is useful information. Take this sheet and your tracker to your doctor. Warning signs never wait for a review date.

ONE PAGE TO HAND ACROSS THE DESK

Appointment Summary

Ten minutes goes quickly. Fill this in the night before from your trackers, and start with the ticked boxes: they change what your doctor does first.



SHEET 07

Name _____ **Date of birth** _____ **Appointment** _____

Why I have come

My main problem, in one sentence

_____

_____

It started _____ It is ☐ constant ☐ comes and goes ☐ getting worse

What I am most worried it might be

_____

Tick any that apply, and say so first

- ☐ Blood in the stool, or black, tarry stool
- ☐ Weight loss I cannot explain
- ☐ Symptoms that wake me at night
- ☐ Trouble or pain swallowing
- ☐ Persistent vomiting
- ☐ Fever with tummy pain
- ☐ A change in bowel habit lasting over 4 weeks
- ☐ Bowel or ovarian cancer, coeliac or IBD in the family
- ☐ New symptoms after age 50

My pattern, from my trackers

Bowel movements a week _____ Usual stool type _____ Range _____

Worst symptom _____ Typical score _____ Worst _____

Days affected in the last 14 _____ Nights woken _____

It is worse with, or after

_____

It is better with

_____

What I have already tried

Food changes, and what happened

_____

_____

Products or medicines, dose, how long, and what happened

_____

_____

EVERYTHING I TAKE: PRESCRIPTIONS, PHARMACY PRODUCTS, VITAMINS, HERBS	DOSE	HOW OFTEN	SINCE

My three questions

1

_____

2

_____

3

_____

What we agreed

Tests, treatment or referral

_____

_____

Review on _____ Sooner if _____

14-DAY TRACKER

Bloating Tracker

Two dots a day: one on waking, one in the evening. Flat in the morning and swollen by night is the commonest pattern, and the gap between the dots shows whether a step is working.



SHEET 08

Name _____ **Day 1 is** _____

DAY	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Date														
BLOATING, 0 NONE TO 10 WORST														
Bloating ● on waking O in the evening Join each pair with a line.	10 8 6 4 2 0													
ALSO TODAY														
Belly visibly swollen	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Stool type 1 to 7														
Stress 0 to 10														
Sleep hours														
STEPS I PRACTISED														
Ate slowly, sitting down	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Walked after a meal	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Belly breathing	○	○	○	○	○	○	○	○	○	○	○	○	○	○
No gum or fizzy drinks	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Fibre step, built up slowly	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Gut-calming relaxation	○	○	○	○	○	○	○	○	○	○	○	○	○	○

One food change at a time

The single food or habit I am changing

_____

From day _____ to day _____ Brought back on day _____

What happened when it came back

_____

_____

After 14 days

Average on waking _____ Average evening _____

Days visibly swollen _____ of 14

My calmest days had this in common

_____

_____

! **Bloating that is frequent or constant**, especially after 50 or with feeling full quickly, pelvic pain or needing to pass urine more often, needs a doctor rather than a longer food trial. Keep eating gluten until coeliac testing has been discussed. Peppermint can worsen reflux.

14-DAY TRACKER

Constipation Tracker

Put a dot on the chart for every movement. Comfort matters as much as frequency: watch whether the dots drift into the green band and the straining score falls.



SHEET 09

Name _____ **Day 1 is** _____

DAY	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Date														
STOOL TYPE: ONE DOT FOR EVERY MOVEMENT, ON THE LINE THAT MATCHES														
7 Watery														
6 Mushy														
5 Soft blobs														
4 Smooth, soft														
3 Cracked sausage														
2 Lumpy sausage														
1 Hard lumps														
EACH DAY														
Movements how many														
Straining 0 to 3														
Felt fully emptied	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Fluids glasses														
Walking minutes														
STEPS I PRACTISED														
Toilet time after breakfast	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Footstool	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Went when I felt the urge	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Psyllium, as on the pack	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Kiwifruit or prunes	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Laxative taken	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Fibre product or laxative

Name _____ Dose _____

Started on day _____ Advised by _____

Review or stop date _____

How it suited me

_____

After 14 days

Movements, week 1 _____ week 2 _____

Days in the green band _____ Longest gap (days) _____

Straining, week 1 average _____ week 2 _____

Fibre can take four weeks to show its full effect. Review again at week four.

! **No movement for three days, or a pharmacy laxative that has not helped after three days?** Speak to a pharmacist or doctor, and do not carry on beyond seven days without advice. Straining hard to pass a soft stool needs assessment before you add more fibre. Blood or black stool: seek medical advice now.

14-DAY TRACKER

IBS Symptom Tracker

Pain and bloating go on the chart; urgency and stool form go underneath, kept separate because they often move independently. Mark the worst each got in the day.



SHEET 10

Name _____ **Day 1 is** _____

DAY	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Date														
WORST OF THE DAY, 0 NONE TO 10 WORST														
Pain and bloating ● pain ○ bloating	10 8 6 4 2 0													
BOWELS														
Urgent trips had to rush														
Movements how many														
Stool types 1 to 7														
CONTEXT														
Stress 0 to 10														
Sleep hours														
STEPS I PRACTISED														
Regular, unhurried meals	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Walk or exercise	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Soluble fibre (psyllium)	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Peppermint oil	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Relaxation or breathing	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Medicine as advised	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Bringing foods back Use with a dietitian during the reintroduction stage of a low-FODMAP diet. Write symptoms 0 to 3 for each day.

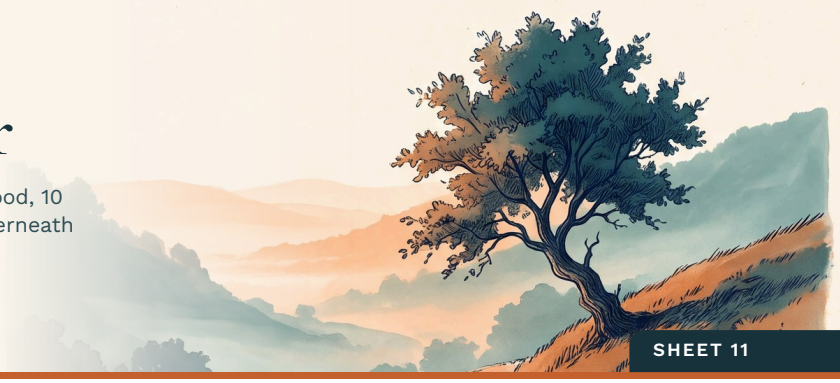
FOOD BROUGHT BACK	AMOUNT	DAY 1	DAY 2	DAY 3	TOLERATED? KEEP, LIMIT OR RETRY

Symptoms lasting more than four weeks need a doctor's assessment before self-treatment. A low-FODMAP diet is temporary and works best with a dietitian; the aim is to bring foods back. Discuss coeliac testing before cutting gluten. Blood, weight loss, night symptoms or fever: see a doctor.

14-DAY TRACKER

Mood and Gut Tracker

Two charts with opposite directions, so read the labels: for mood, 10 is your best; for worry, 10 is your worst. Gut symptoms sit underneath so you can see which moves first.



SHEET 11

Name _____ **Day 1 is** _____

DAY	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Date														
MOOD: 10 IS THE BEST YOU FEEL														
Mood ● one dot a day (10 / 8 / 6 / 4 / 2 / 0)														
WORRY: 10 IS THE WORST IT GETS														
Worry O one dot a day (10 / 8 / 6 / 4 / 2 / 0)														
ALSO TODAY														
Gut symptoms 0 to 10														
Sleep hours														
Movement minutes														
STEPS I PRACTISED														
Walk or other exercise	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Regular meals	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Mediterranean-style meal	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Breathing or relaxation	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Talked to someone	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Medicine as prescribed	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Fill this in now, while you feel able

Emergency number where I live _____

Urgent mental-health line _____

Someone I can ring, day or night _____

My doctor or therapist _____

After 14 days

On days my gut was calmer, my mood was _____

What lifted a day, even slightly _____

If you cannot keep yourself safe, call your emergency number now. Thoughts of suicide or self-harm need urgent support today. Low mood most of the day for two weeks deserves a doctor's appointment. This tracker sits alongside treatment; never start, stop or change an antidepressant on your own.

14-DAY TRACKER

Energy and Cravings Tracker

Three dots a day trace your energy from morning to evening. Cravings and hunger go underneath. There is no weighing here unless you choose it, and never more than once a week.



SHEET 12

Name _____ **Day 1 is** _____

DAY	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Date														
ENERGY, 0 FLAT TO 10 FULL OF ENERGY														
Energy ● mid-morning ○ mid-afternoon □ evening 10 8 6 4 2 0														
HUNGER AND CRAVINGS														
Hunger before main meal 0 to 10														
Craving time it hit														
Ate when not hungry	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Packaged snacks, drinks how many														
CONTEXT														
Sleep last night hours														
Stress 0 to 10														
Movement minutes														
STEPS I PRACTISED														
Protein and fibre at breakfast	○	○	○	○	○	○	○	○	○	○	○	○	○	○
One food swap	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Paused before a snack	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Wind-down routine	○	○	○	○	○	○	○	○	○	○	○	○	○	○

The afternoon dip

It usually hits at _____ and lasts _____

Lunch on the worst dip days

_____

Lunch on the days with no dip

_____

After 14 days

Average energy: morning _____ afternoon _____ evening _____

Cravings came most often after

_____

Weight, optional, weekly at most: week 1 _____ week 2 _____

! **Losing weight without trying, or tiredness that has lasted for weeks?** See your doctor: thyroid problems, diabetes, anaemia and sleep apnoea are all checkable. An afternoon dip on its own cannot show a blood-sugar problem. If food or weight is a source of distress, skip the weight line and ask for support.

14-DAY TRACKER

Reflux Tracker

Reflux is about timing. Record when the last meal ended and when you lay down; the tracker works out the rest. Night symptoms have their own row because they matter most to your doctor.



SHEET 13

Name _____ **Day 1 is** _____

DAY	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Date														
HEARTBURN AT ITS WORST, 0 NONE TO 10														
Heartburn ● daytime worst ○ night-time worst (10 / 8 / 6 / 4 / 2 / 0)														
SYMPTOMS														
Episodes how many														
Acid or food coming back up	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Woken at night by it	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Cough, hoarse or sore throat	○	○	○	○	○	○	○	○	○	○	○	○	○	○
THE EVENING														
Last meal finished time														
Lay down time														
Three hours or more between	○	○	○	○	○	○	○	○	○	○	○	○	○	○
STEPS AND REMEDIES														
Smaller evening meal	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Stayed upright after eating	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Bed head raised	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Slept on left side	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Antacid or alginate doses														
PPI or other medicine taken	○	○	○	○	○	○	○	○	○	○	○	○	○	○

One suspected trigger

The food or drink I am testing

_____

Left out from day _____ to day _____ Brought back day _____

Result

_____

After 14 days

Days with heartburn: week 1 _____ week 2 _____

Nights woken _____ Days I needed a remedy _____

Heartburn on two or more days a week, or a remedy most days, is worth a doctor's review.

! **Chest pain or pressure that is sudden, persists, or spreads to the arm, neck, jaw or back**, or comes with sweating or breathlessness, is an emergency: do not assume it is heartburn. Trouble swallowing, vomiting blood, black stool or weight loss need prompt assessment. Do not stop a prescribed PPI on your own.

COURSE AND RECOVERY · 14 DAYS

Antibiotic Recovery Tracker

Start on the first day of the course and keep going after it ends. Tick each dose so none is missed, and watch stool form: it is the earliest sign of whether your gut is settling.



SHEET 14

Name _____ **Day 1 is** _____

DAY	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Date														
THE COURSE														
On antibiotics today	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Doses taken tick each one														
STOOL TYPE: ONE DOT FOR EVERY MOVEMENT														
7 Watery														
6 Mushy														
5 Soft blobs														
4 Smooth, soft														
3 Cracked sausage														
2 Lumpy sausage														
1 Hard lumps														
EACH DAY														
Movements how many														
Fluids glasses														
Bloating 0 to 10														
Thrush symptoms	○	○	○	○	○	○	○	○	○	○	○	○	○	○
BRINGING THE GUT BACK														
Fibre food	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Fermented food	○	○	○	○	○	○	○	○	○	○	○	○	○	○
A plant I have not had this week	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Probiotic, if advised	○	○	○	○	○	○	○	○	○	○	○	○	○	○

My course

Antibiotic _____ For _____

Prescribed from _____ to _____ Doses a day _____

Dose times _____ With food? _____

What the leaflet says about dairy, alcohol, other medicines _____

Who to call about diarrhoea

Surgery or pharmacy _____

Out of hours _____

Diarrhoea began on day _____

! **Diarrhoea during or after antibiotics: ring your doctor rather than waiting.** Blood, fever, marked pain, not keeping fluids down, or diarrhoea beyond seven days needs urgent advice, and do not take loperamide. Finish the course exactly as prescribed. Ask before any probiotic if your immunity is weakened.

ONE SHEET PER WEEK · FOUR WEEKS TO BUILD THE HABIT

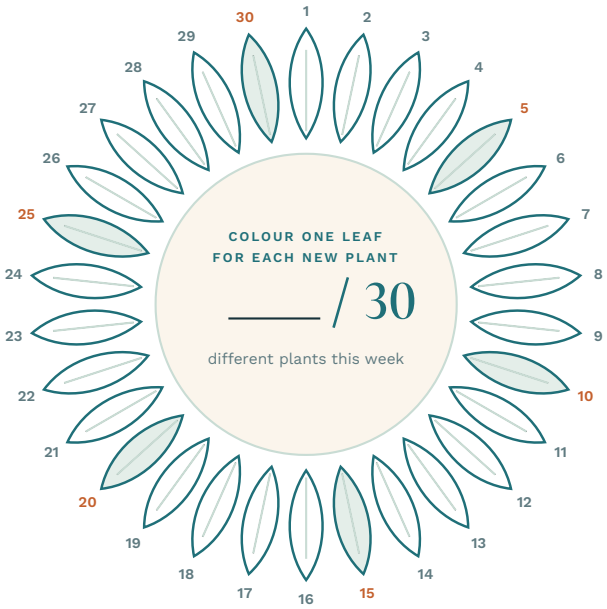
30 Plants a Week

Write each new plant in its group and colour a leaf. Repeats do not count twice, so the wheel rewards variety. The grid below keeps an eye on comfort.



SHEET 15

Name _____ **Week** _____ **starting** _____



Vegetables

_____

_____

_____

_____

Fruit

_____

_____

_____

_____

Beans and lentils

_____

_____

_____

_____

Wholegrains

_____

_____

_____

_____

Nuts and seeds

_____

_____

_____

_____

Herbs and spices

_____

_____

_____

_____

DAY	1	2	3	4	5	6	7
Date							
Fibre foods I added							
Fluids glasses							
Wind or bloating 0 to 10							
Stool type 1 to 7							

Week 1

Plants _____ / 30

Comfort 0 to 10 _____

Week 2

Plants _____ / 30

Comfort 0 to 10 _____

Week 3

Plants _____ / 30

Comfort 0 to 10 _____

Week 4

Plants _____ / 30

Comfort 0 to 10 _____

! **One point for each different plant in the week.** Thirty is a guide for building variety, and there is no pass mark. Add fibre gradually and step back if wind or bloating builds. A narrowed bowel, a past blockage or swallowing problems need a doctor's advice before more fibre or psyllium.

14-DAY TRACKER

Fermented Foods Tracker

Start with a spoonful. Log what you tried with a letter and watch the wind and bloating line. If it stays flat for three days, the portion can grow.



SHEET 16

Name _____ **Day 1 is** _____

DAY	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Date														
WHAT I HAD: Y YOGHURT, K KEFIR, S SAUERKRAUT, KI KIMCHI, M MISO, T TEMPEH, KB KOMBUCHA, O OTHER														
Food letter														
Portion spoons or ml														
Label says live	○	○	○	○	○	○	○	○	○	○	○	○	○	○
WIND OR BLOATING, 0 NONE TO 10 WORST														
Wind or bloating ● worst of the day	10 / 8 / 6 / 4 / 2 / 0													
ALSO TODAY														
Stool type 1 to 7														
Other reaction headache, flushing	○	○	○	○	○	○	○	○	○	○	○	○	○	○
STEPS I PRACTISED														
Tried a new food	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Kept the portion small	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Checked the label	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Ate fibre with it	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Label comparison Chilled and unpasteurised usually means live. Heat-treated or shelf-stable usually does not.

PRODUCT AND BRAND	LIVE, OR HEAT-TREATED?	SUGAR PER 100 G	SALT PER 100 G	PRICE PER PORTION	BUY AGAIN?

Foods that suit me

_____

Foods to leave for now

_____

! **Fermented foods are an everyday food, and they do not treat any condition.** If your immunity is weakened or you are seriously ill, ask your care team before eating live or unpasteurised foods. In pregnancy avoid unpasteurised dairy. Never taste a home batch that looks mouldy or smells putrid: discard all of it.

14-DAY TRACKER

Food Swaps Tracker

Two swaps you can afford and keep beat a perfect week you cannot repeat. Tick what you managed and plot energy and gut comfort, so you can see whether the swaps repay the effort.



SHEET 17

Name _____ **Day 1 is** _____

DAY	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Date														
SWAPS MADE TODAY														
Sweet or fizzy drink swapped	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Breakfast swapped	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Snack swapped	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Main meal cooked from scratch	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Read an ingredients list	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Packaged items eaten rough count														
HOW I FELT, 0 POOR TO 10 VERY GOOD														
Energy and gut ● energy O gut comfort 10 8 6 4 2 0														
Spent on food optional														

Swap planner Start with drinks, then one breakfast, then one snack.

WHAT I BUY NOW	WHAT I COULD HAVE INSTEAD	COST PER PORTION NOW / SWAP	EXTRA TIME (MINUTES)	WORTH KEEPING?

Ingredients I keep seeing on my labels

_____

_____

The two swaps I will keep

_____

_____

! **Every food can have a place.** A processing label alone does not tell you whether a food is harmful. Do not cut out whole food groups. If you are underweight, have a history of disordered eating or have active inflammatory bowel disease, talk to your care team before making large changes.

4-WEEK TRACKER

Movement Tracker

A dot for the minutes you moved each day, across four weeks. The line should climb gently. The usual adult guideline is 150 minutes a week; build towards it at your own pace.



SHEET 18

Name _____ **Day 1 is** _____

DAY	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28
MINUTES OF MOVEMENT: ABOVE 60, PUT THE DOT ON THE TOP LINE AND WRITE THE NUMBER																												
Minutes ● walking, cycling, swimming, anything that counts — 60 / 50 / 40 / 30 / 20 / 10 / 0																												
THE SESSION																												
Effort 0 to 10																												
Brisk: could talk, not sing	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Strength routine	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Walk after a meal	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Broke up long sitting	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
GUT AND MOOD																												
Gut symptoms during exercise	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Gut symptoms today 0 to 10																												
Mood 10 = best																												
Stool type 1 to 7																												

Week 1

Total minutes _____

Strength sessions _____

Week 2

Total minutes _____

Strength sessions _____

Week 3

Total minutes _____

Strength sessions _____

Week 4

Total minutes _____

Strength sessions _____

If exercise upsets my gut

Activity and time of day _____

Last meal: what, and how long before _____

What happened, and what I will change next time

_____

After four weeks

The activity I am most likely to keep doing

_____

What changed in my gut, sleep or mood

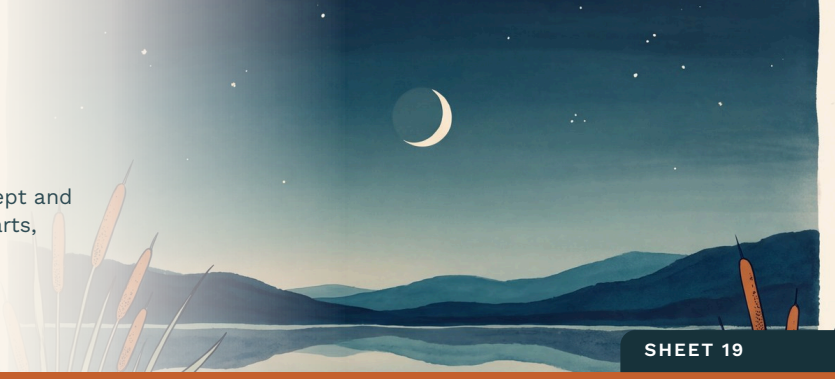
_____

! **Stop and get emergency help** for chest pain that persists or spreads, fainting, or palpitations with breathlessness. Check with a clinician before starting if you have heart, lung or kidney disease, diabetes, or dizziness on exertion. Leave two to three hours between a large meal and a hard session.

14 NIGHTS · FILL IN EACH MORNING

Sleep and Stress Diary

Each night is a bar from 6 pm to noon. Shade the hours you slept and the page becomes a picture of your nights: you will see late starts, broken stretches and drifting wake-up times at a glance.



SHEET 19

Name _____ **Night 1 is** _____

↓ the time you got into bed **Shade** the hours you were asleep **W** awake in the night ↑ the time you got up **Z** a daytime nap

EXAMPLE



In bed 10.45 pm, asleep 11.30, awake 2.40 to 3.10, woke 6.45, up 7.20.

NIGHT	PM 6 7 8 9 10 11 MIDNIGHT 12 1 2 3 4 5 AM 6 7 8 9 10 11	QUALITY 0-10	STRESS 0-10	LAST caffeine	ALCOHOL	SCREENS off 1 h	GUT woke me
1 date					○	○	○
2 date					○	○	○
3 date					○	○	○
4 date					○	○	○
5 date					○	○	○
6 date					○	○	○
7 date					○	○	○
8 date					○	○	○
9 date					○	○	○
10 date					○	○	○
11 date					○	○	○
12 date					○	○	○
13 date					○	○	○
14 date					○	○	○

After 14 nights

Usual time asleep (hours) _____ Nights woken _____

Wake-up time varied by (hours) _____ Average stress _____

My best nights followed days when

_____

Things to tell a doctor

- ☐ Someone has noticed my breathing pause, or I wake gasping
- ☐ I am sleepy enough in the day to worry about driving
- ☐ Poor sleep three nights a week for three months
- ☐ Gut pain wakes me from sleep

! **Use this sheet as a diary of your sleep.** Cutting down your time in bed needs trained support, so do not do it from these numbers. Never drive when sleepy. Do not stop prescribed sleeping tablets suddenly, and do not use alcohol to get to sleep.

FULL LIST PLUS 14-DAY SYMPTOM RECORD

Medicines and Gut Record

List everything you take, then mark the day any medicine starts or changes. If a symptom line rises a few days later, you have something specific to show your pharmacist.



SHEET 20

Name _____ **Pharmacy** _____ **Day 1 is** _____

MEDICINE, VITAMIN, HERB OR SUPPLEMENT	WHAT FOR	DOSE	WHEN I TAKE IT	WITH FOOD OR EMPTY STOMACH	STARTED	PRESCRIBED, OR BOUGHT MYSELF

DAY	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Date														
GUT SYMPTOMS, 0 NONE TO 10 WORST														
Gut symptoms ● nausea ○ tummy pain ☐ heartburn 10 8 6 4 2 0														
Stool type 1 to 7														
Movements how many														
All doses taken as directed	○	○	○	○	○	○	○	○	○	○	○	○	○	○
New or changed medicine	○	○	○	○	○	○	○	○	○	○	○	○	○	○

Changes agreed with my doctor or pharmacist Only changes a professional has agreed go here.

DATE	CHANGE AGREED, EXACTLY AS ADVISED	ADVISED BY	REVIEW DATE

Never stop, skip, switch or re-time a prescribed medicine to test a symptom. Bring this sheet to a pharmacist instead. Include painkillers bought over the counter, iron, vitamins and herbs. Vomiting blood, black sticky stool or sudden severe tummy pain is an emergency; do not put dark stool down to iron if it is tarry.

14-DAY TRACKER

Time Outdoors Tracker

A dot for your minutes outside each day. Twenty minutes in daylight is the manual's starting point; a walk round the block counts as much as a day in the hills.



SHEET 21

Name _____ **Day 1 is** _____

DAY	1	2	3	4	5	6	7	8	9	10	11	12	13	14
Date														
MINUTES OUTDOORS: ABOVE 60, PUT THE DOT ON THE TOP LINE AND WRITE THE NUMBER														
Minutes outside ● total in daylight	60 / 50 / 40 / 30 / 20 / 10 / 0													
WHAT KIND OF TIME														
Out before midday	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Green space or water park, trees, river	○	○	○	○	○	○	○	○	○	○	○	○	○	○
With someone	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Gardening or hands in soil	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Where I went initial														
HOW I FELT														
Mood 10 = best														
Sleep last night 0 to 10														
Gut symptoms 0 to 10														

My places

Five minutes from my door _____

A green space I can reach _____

Bad-weather or low-energy fallback _____

Someone who might come _____

Before more sun

- ☐ Asked a pharmacist whether my medicines increase sun sensitivity
- ☐ Know my local sun-protection advice
- ☐ Asked about vitamin D if I am rarely outdoors

! **Use this sheet to build a daily outdoor routine.** Protect your skin as local advice recommends. Some medicines make skin more sensitive to sun, so check before spending longer outside. Wash your hands after gardening. Vitamin D supplements are an individual decision for you and your clinician.

4-WEEK TRACKER

Mind-Gut Practice Tracker

These practices work by repetition, so the tracker runs for four weeks. Tick the days you practised and plot gut and stress scores; expect the lines to shift slowly, over weeks rather than days.



SHEET 22

Name _____ **Day 1 is** _____

DAY	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28
GUT SYMPTOMS AND STRESS, 0 NONE TO 10 WORST																												
Gut and stress ● gut symptoms ○ stress	10 8 6 4 2 0																											
PRACTICE: WRITE THE MINUTES																												
Belly breathing																												
Breathing after meals																												
Gut-directed relaxation 15 min																												
Muscle relaxation or pause																												
Thought check	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
Therapy session or app	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○
ALSO TODAY																												
Sleep hours																												
Stool type 1 to 7																												

Week 1

Average gut score _____

Average stress _____

Days practised _____

Week 2

Average gut score _____

Average stress _____

Days practised _____

Week 3

Average gut score _____

Average stress _____

Days practised _____

Week 4

Average gut score _____

Average stress _____

Days practised _____

A thought I noticed when symptoms flared

The thought

_____

A fairer way to put it

_____

After four weeks

The practice I will keep, and when in the day

_____

_____

Keep breathing gentle: no breath-holding and no forcing. Stop if you feel dizzy, breathless or distressed. Never practise while driving. With a history of trauma, dissociation, psychosis or epilepsy, ask your care team before using imagery or hypnosis recordings. These practices sit alongside medical care.