FOOD ALLERGY & ELIMINATION DIET REACTION LOG

SYMPTOM ONSET, DIGESTIVE BIOFEEDBACK & INGREDIENT TRIGGERS

DATE: _____/_____/20____ **DIET DAY: DAY _____ / 30** **PHASE: [ ] Elimination [ ] Re-Introduction** **TEST FOOD: _____**

BASELINE GUT SCORE: [1][2][3][4][5] | WATER: _____ oz | ALLERGY MEDS TAKEN: [ ] None [ ] Antihistamine [ ] Inhaler

SECTION 1: COMPREHENSIVE DAILY INGESTION LOG (PRECISE INGREDIENTS & HIDDEN OILS)

TIME	MEAL / SNACK	FULL INGREDIENT LIST (SPICES, OILS & ADDITIVES)	TESTED ALLERGEN / SUSPECT	PORTION SIZE
____:____	Breakfast			
____:____	Lunch			
____:____	Dinner			
____:____	Snacks / Beverages			

SECTION 2: MULTI-SYSTEM PHYSIOLOGICAL REACTION AUDIT (0=NONE, 1=MILD, 2=MODERATE, 3=SEVERE)

BODY SYSTEM	REPRESENTATIVE SYMPTOMS SCANNE	ONSET TIME	SEVERITY (0-3)	DURATION	RELIEF / INTERVENTION
1. Gastrointestinal	Bloating, Cramps, Acid Reflux, Nausea, Diarrhe	____ min / hrs	[0] [1] [2] [3]	_____ hrs	
2. Dermatological	Eczema Flare, Itching, Hives, Facial Flushing, S	____ min / hrs	[0] [1] [2] [3]	_____ hrs	
3. Respiratory	Sinus Congestion, Sneezing, Wheezing, Throat	____ min / hrs	[0] [1] [2] [3]	_____ hrs	
4. Neurological	Brain Fog, Migraine, Dizziness, Cognitive Slugg	____ min / hrs	[0] [1] [2] [3]	_____ hrs	
5. Energy & Mood	Lethargy, Post-Prandial Crash, Irritability, Anxie	____ min / hrs	[0] [1] [2] [3]	_____ hrs	
6. Musculoskeletal	Joint Inflammation, Muscle Soreness, Stiff Neck	____ min / hrs	[0] [1] [2] [3]	_____ hrs	

DAILY CLINICAL VERDICT FOR TEST FOOD / INGREDIENT:

[ ] SAFE TOLERANCE (No reactions detected) [ ] SUSPECTED TRIGGER (Mild symptoms) [ ] DEFINITE ALLERGEN / INTOLERANCE (Severe)

Clinical Notes / Doctor Discussion: _____

Action Plan for Next 48 Hours: _____