
Cup and Cabinet Inventory

Tick what you've had in **the past seven days**, with the times (Chapter 11).

- ☐ Coffee, strong tea, milk tea, energy drinks, caffeinated soft drinks.
Cups a day: _____ Last one at: _____
- ☐ Alcohol. Days a week: _____
- ☐ Cigarettes, vapes, other nicotine.
- ☐ Decongestants, or cold and flu remedies containing decongestants.
- ☐ Drowsy antihistamines, non-prescription sleep aids.
- ☐ Painkillers containing caffeine or codeine.
- ☐ "Energy", "fat-burning", "adrenal support" or "thyroid support" supplements.

Prescription medicines (name, dose, when started):

One thing I'll cut back gradually for two weeks (not a prescription medicine): _____

Don't stop prescription medicines on your own. Take this list to your doctor or pharmacist.