

Start Date	Day 8	Day 9	Day 10	Day 11	Day 12	Day 13	Day 14	
How many times did you attempt to empty your bowels today?								
Indicate the number of times you actually passed stool								
Overall , do you feel like you have completely emptied your bowels today?	Yes <input type="checkbox"/> No <input type="checkbox"/> Did not open bowels <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> Did not open bowels <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> Did not open bowels <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> Did not open bowels <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> Did not open bowels <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> Did not open bowels <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> Did not open bowels <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> Did not open bowels <input type="checkbox"/>
Did you use laxatives today?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Did you use a suppository today?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	
Did you use rectal irrigation today?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	

Please bring this diary to your biofeedback hospital appointment