Please record your food intake for <u>four</u> days.

The days do not need to be consecutive, but they do need to be "typical" days. Please note any symptoms in the right column.

Please be complete and thorough.

Each day record all the items you eat and drink. Be sure to include the approximate amount of each item.

Name: _____

Quality of sleep last night: (poor) 1 2 3 4 5 (great)
Hours of sleep last night:

BREAKFAST:
Time:
□ Home
□ Restaurant

MID-MORNING SNACK:
Time:
□ Home
□ Restaurant

LUNCH:
Time:
□ Home
□ Restaurant

MID-AFTERNOON SNACK:
Time:
□ Home
□ Restaurant

DINNER:
Time:
□ Home
□ Restaurant

NIGHTTIME SNACK:
Time:
□ Home
□ Restaurant

Glasses of <u>plain</u> water consumed today:

Notable Symptoms & Time:

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