DIET & SYMPTOM RECORD

NAME:

FOOD INTAKE List all foods & drinks consumed		REACTIONS Record any reactions you may have to your food and beverage intake	
		BEFORE	2 HOURS AFTER
TODAY'S DATE:	RECORD DATA IN EVERY CELL BELOW	Rate your sleep last night: Poor < 1 2 3 4 5 > Excellent	Comment:
Time ___:___ **BREAKFAST**	Physical		
	Appetite		
	Cravings		
	Energy		
	Mind		
	Emotions		
Time ___:___ ***Snack***	Physical		
	Appetite		
	Cravings		
	Energy		
	Mind		
	Emotions		
Time ___:___ **LUNCH**	Physical		
	Appetite		
	Cravings		
	Energy		
	Mind		
	Emotions		
Time ___:___ ***Snack***	Physical		
	Appetite		
	Cravings		
	Energy		
	Mind		
	Emotions		
Time ___:___ **DINNER**	Physical		
	Appetite		
	Cravings		
	Energy		
	Mind		
	Emotions		
Time ___:___ ***Snack***	Physical		
	Appetite		
	Cravings		
	Energy		
	Mind		
	Emotions		

How did you feel overall today from this diet? Did you do well or poorly on it?