MEAL	Day ___	Emotions/Symptoms during the day	Day ___	Emotions/Symptoms during the day	Day ___	Emotions/Symptoms during the day
Time: **Morning Meal & Beverage**		**Weight ______**		**Weight _____**		**Weight _____**
Snack						
Time: **Noon Meal & Beverage**						
Snack						
Time: **Evening Meal & Beverage**						
Snack						
Additional Foods & Beverages						
Water (ozs/day						
Fats/Oils used						
Exercise (type): **Duration:**		**Stress**: Level of stress: High Medium Low		**Stress**: Level of stress: High Medium Low		**Stress**: Level of stress: High Medium Low
Relaxation (type): **Duration:**		**Sleep:** # hrs: ___ Quality: Rested? Y / N		**Sleep:** # hrs: ___ Quality: Rested? Y / N		**Sleep:** # hrs: ___ Quality: Rested? Y / N

NAME: ____ **Date:** ______________

DIET / ACTIVITY REPORT:

- Please take time to complete the following survey carefully and accurately.
- List in detail the quantity and the exact nature of all the foods and beverages consumed (ie. Frozen, canned,
- organic, fast food etc.). Please indicate if the food was raw or cooked.
- Please complete the exercise portion at the bottom.
- And record any periods of relaxation or meditation.
- Each day, in the following column, indicate the emotions that may have provoked eating or snacking, and also if any symptoms accompanied or followed the eating of any food.

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