FOOD JOURNAL

Instructions: With approximate times and amounts, write down everything you put into your mouth (i.e.: liquids, foods, gum, nicotine containing products, nutritional supplements, over the counter medicine, prescription drugs, etc.)

Name ________________________________ Age _______ Weight _______ Height _______ Blood Type _______ Phone # ______________________

Date:	**DAY 1**		Date:	**DAY 2**		Date:	**DAY 3**	
Time	**Item Consumed**	**Amt.**	**Time**	**Item Consumed**	**Amt.**	**Time**	**Item Consumed**	**Amt.**

Date:	DAY 4		Date:	DAY 5		Date:	DAY 6		Date:	DAY 7	
Time	**Item Consumed**	**Amt.**	**Time**	**Item Consumed**	**Amt.**	**Time**	**Item Consumed**	**Amt.**	**Time**	**Item Consumed**	**Amt.**