Food Journal

Name: _____ Date: _____ Mon. Tues. Wed. Thurs. Fri. Sat. Sun. Weight: _____

Food & Drink: (everything, including tiny bites) … *also indicate approximate amounts

	Time	Food/Beverage	Mood Before	Mood After
Pre-Breakfast				
Breakfast				
Snack (mid-morning)				
Lunch				
Snack (mid-afternoon)				
Dinner				
Snack (evening)				
Medications / Supplements / Herbs / Other				

What did you notice (physically, mentally) after eating any of the above foods?

Water Intake:	○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ cups (250 mL in one cup)	
Digestion:	Number of Bowel Movements:	
	Description (size, colour, undigested food, etc.):	
	Other observations (gas/bloating, burping, acid stomach, etc.):	
Cravings:	☐ Salty ☐ Sweet ☐ Spicy ☐ Chocolate ☐ Coffee ☐ Alcohol ☐ Starches (breads, donuts, etc.)	

Energy Level: (low energy) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (high energy)

Stress Level: (low stress) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (high stress)

Mood(s) & Emotions: How would you describe your mood(s) today?

Morning	Afternoon	Evening

Exercise (#min/type):	

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