Nutritional Sciences
TAKE CONTROL OF YOUR HEALTH

FOOD RECORD

Weight: _____

Height: _____

NAME: _____ Birthdate (mm/dd/yyyy) _____

Complete this form as accurately as possible, using the examples as a guide (use brand names of processed/packaged and premade products)

- Record all foods and beverages (not including water), you consume from the time you wake up to the time you go to bed.
- Complete **3 days** worth of your regular eating habits.

TIME	FOOD/DRINK	TYPE	PREPARATION	AMOUNT
8:00 A.M.	*Bagel*	*White - Plain*	*Toasted*	*Half of a regular one*
8:00 A.M.	*Butter*	*Salted*		*1 TBSP (size of my thumb)*
10:00 A.M.	*Coffee*	*Caffeinated*	*With 2 cream/2 sugar*	*2 cups (500ml)*
5:00 P.M.	*Chicken*	*Leg*	*Fried*	*2*

TIME	FOOD/DRINK	TYPE	PREPARATION	AMOUNT

Please submit this form along with your Nutrition Consult questionnaire to your Nutritionist a minimum of 3 days before your appointment time for dietary analysis via any of the following methods: