OptimalHealth
& Wellness Center, Ltd.
800 Roosevelt Rd., Bld. D, Ste. 104 • Glen Ellyn, IL 60137 • 630-858-9900

FOOD ASSESSMENT DIARY

Patient Name: ____________

Date: ____________

	Food & Beverage (Please include as much detail as possible including serving size	Time of Mea	Where Meal Wa Consumed*	How Meal Was Consumed**
Breakfast		A.M./P.M.		
		A.M./P.M.		
		A.M./P.M.		
		A.M./P.M.		
		A.M./P.M.		
Lunch		A.M./P.M.		
		A.M./P.M.		
		A.M./P.M.		
		A.M./P.M.		
		A.M./P.M.		
Dinner		A.M./P.M.		
		A.M./P.M.		
		A.M./P.M.		
		A.M./P.M.		
		A.M./P.M.		

*Please indicate if the meal was consumed at Home (H), Work Cafeteria (WC), Restaurant ® or Other (Please Specify)

** Please indicate how the meal was consumed. Alone (A), With Others (WO), Sit-Down Meal (S), On the-go (OG), or Other (Please Specify)

Snacks (Include coffee, soda, candy, gum, etc.)

Snack	Time
	Time: ______ A.M./P.M.
	Time: ______ A.M./P.M.
	Time: ______ A.M./P.M.
	Time: ______ A.M./P.M.
	Time: ______ A.M./P.M.
	Time: ______ A.M./P.M.

Food Groups:

As you write down the foods you eat at each meal, check the boxes for the correspoding group per ser

Dairy																
Meats																
Grains (including rice and corn)																
Fruits																
Vegetables																
Sugar (Soda, Candy, Etc.)																
Chips and Junk Food																

Water Intake:

Mark off each eight-ounce serving of water you drink today.

Bowel Movements:

1. Time ______________ A.M./P.M.
2. Time ______________ A.M./P.M.
3. Time ______________ A.M./P.M.
4. Time ______________ A.M./P.M.
5. Time ______________ A.M./P.M.
6. Time ______________ A.M./P.M.

Notes:

file: Food Diary