***This food record will help the dietitian assess your daily food choices and provide you with individual recommendations suited to your likes and lifestyle. Please have the diary with you for your appointment.***

### Tips to keep in mind:

### *There's nothing to be gained by trying to look good on these forms*!

###  We can only help if you record what you really eat. There is no judgement on any of your food choices.

### *Write everything down.*

###  i.e. a piece of candy, a handful of pretzels, a can of soda pop or a small donut.

### *Write it as you eat it, not at the end of the day.*

###  (unless you forget, then something is better than nothing)

### *Be specific*.

###  Include items such as gravy on meat, butter on vegetables, or cream and sugar in coffee.

### *Measure* amounts.

###  For example: use ‘cups’ to measure vegetables, pasta, rice, cereal: 1½ cups cereal, 2 cups pasta etc.  If eating meat, a 3-ounce cooked portion is about the size of a deck of cards.  Estimate things such as cake etc.

### *Do not change your eating habits while you are keeping your food record.*

###  The food record is to show your regular food habits. The dietitian will help you make food changes  based on what is realistic and feasible for you and your lifestyle.

### *Please complete the brief background information on the next page.*

###

### Please complete this brief background information prior to your visit:

### HEALTH

### Do you eat out/order take-in? □ No □Yes H*ow often & where:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Who does the cooking/food preparation in your home? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Is salt added to the cooking/plate? □ No □ Yes

### Who does the grocery shopping for your household? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Do you consume dairy products? □ No □ Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Do you take vitamins, minerals, or herbal supplements? □ No □ Yes

### *If yes, please list:* ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Do you have any food allergies or intolerances? □ No □ Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### GI/Bowel concerns? □ None □ Diarrhea □ Constipation □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### What is your fluid intake?: *Water:* \_\_\_\_\_\_\_cups/day *Coffee*\_\_\_\_\_\_\_cups/day (milk/cream/sugar) *Tea* \_\_\_\_\_\_\_cups/day

### *Alcohol* (wine, liquor, beer) \_\_\_\_\_\_\_/day or week (circle one) *Milk*\_\_\_\_\_\_\_/day (1%, 2%, 3.25%) *Juice* \_\_\_\_\_\_\_\_/day

### *Pop* \_\_\_\_\_\_\_cans/say *Iced tea* \_\_\_\_\_\_\_day Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Stress Levels: □ Low □ Average □ High □ Very high (Currently or chronic/on-going)

### Sleep (*most nights*): □ 6 hours or less □ 7-9 hours □ 9 hours or more

### □ Wake up rested □ Wake up tired Other: ­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Physical Activity

### Are you currently doing any walking? □Yes □No How much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Are you doing any other physical activity? □Yes □No What kind: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Do you have any barriers to physical activity? □Yes □No If yes*:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### Do you have any recreational activities/work/hobbies? □Yes □No

###  *Please specify type and frequency:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| --- | --- | --- |
| Time | Food consumed | Amount |
| Example:9am | Cereal - Frosted Mini-wheats1% milkBoiled eggs**Coffee, 2 TBSP 10% cream, 1TBSP sugar** | 2.5 cups250ml or 1cup2 large500ml or 2cups |
| **Where** do you eat your meals (circle all): Kitchen table In front of TV/screen Bedroom Couch Car Desk Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Mood** when eating today (circle all): Stressed Distracted Calm Happy Frustrated Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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