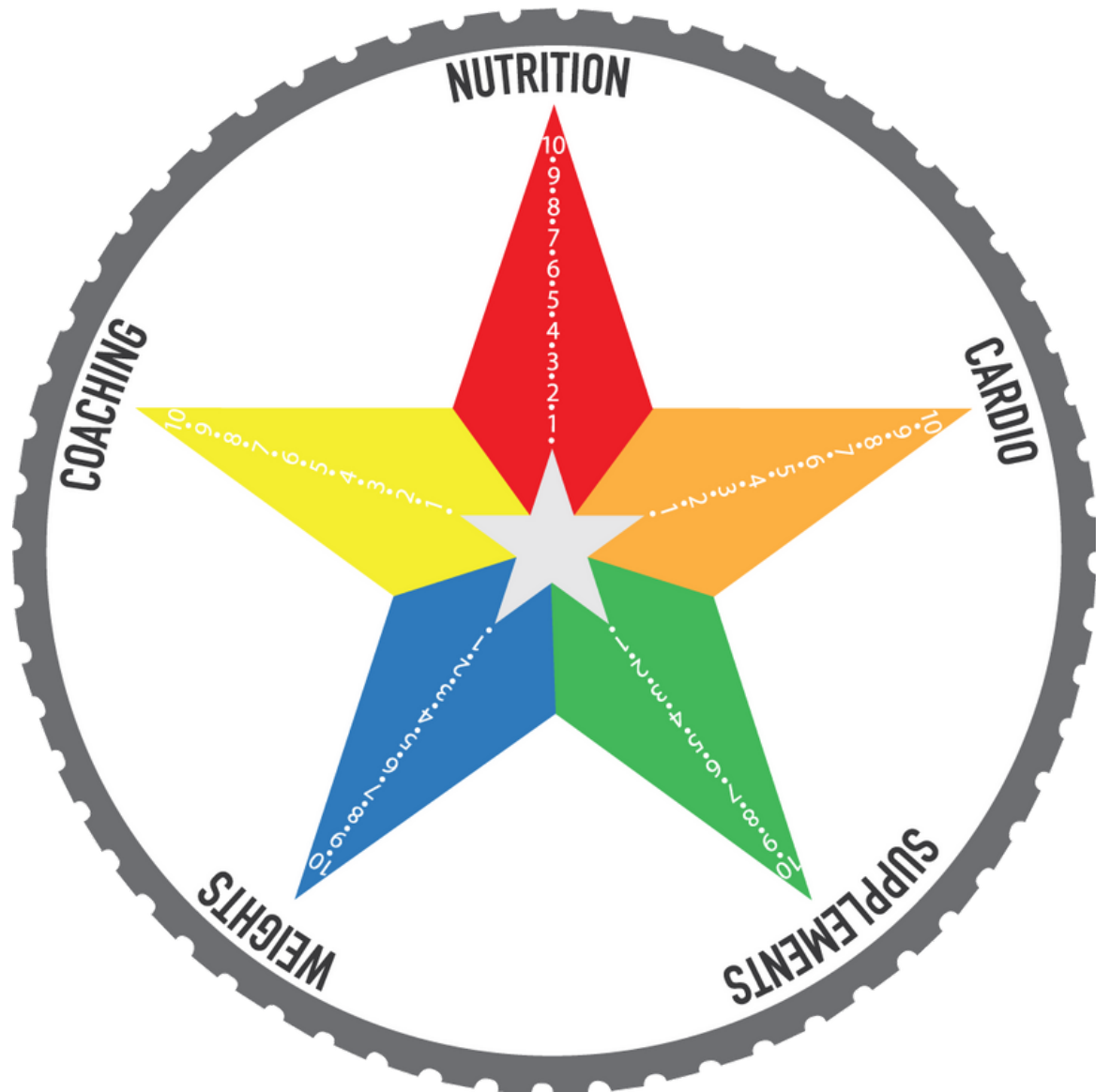




NUTRITION WORKBOOK



FIRST NAME:

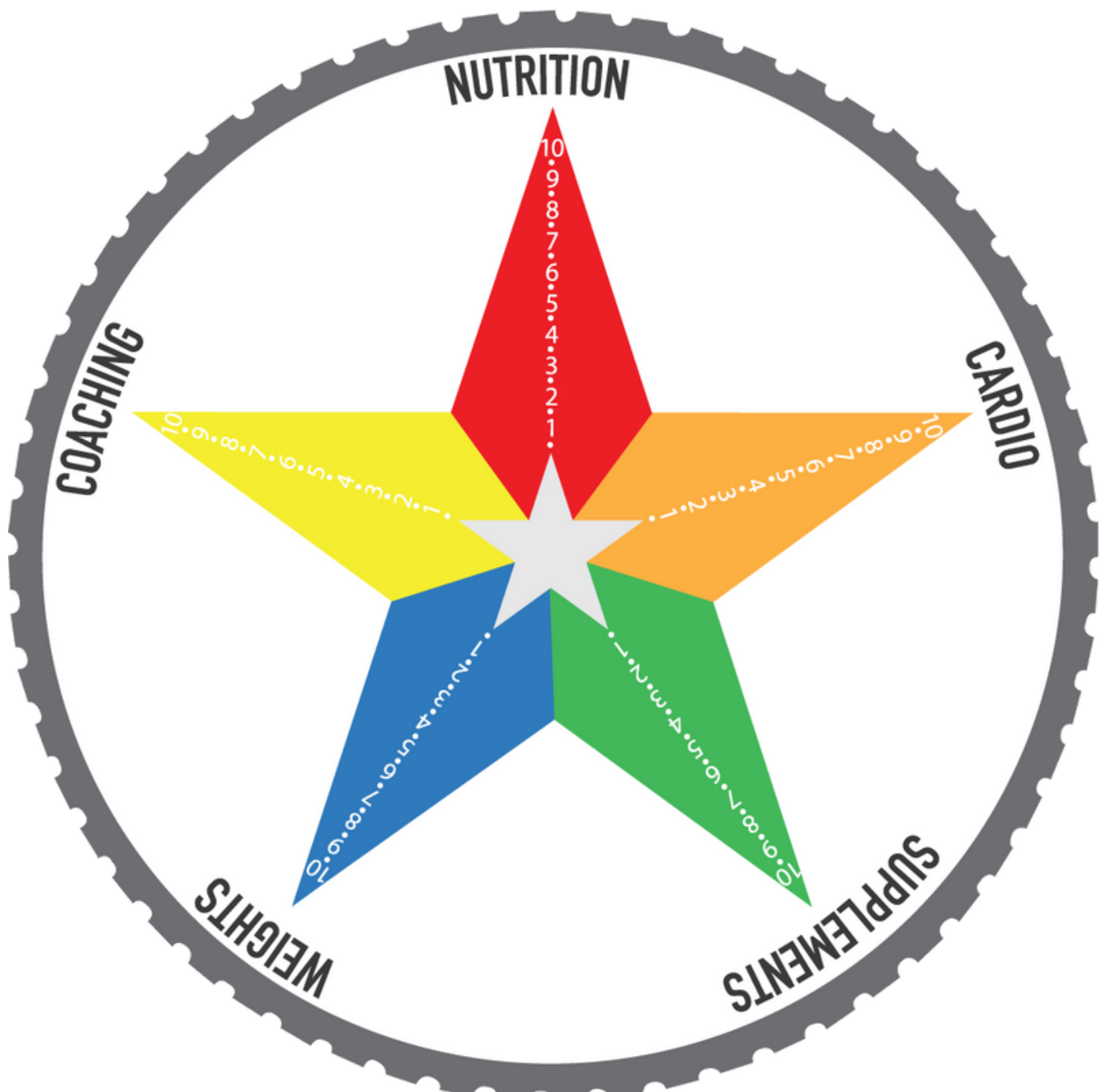
LAST NAME:

PHONE:

EMAIL:

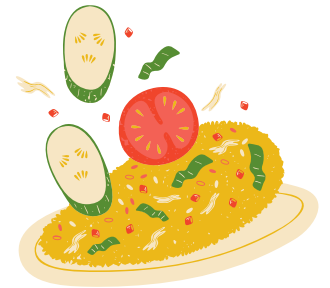
NOTES:

THE FUNDAMENTALS OF HEALTH & FITNESS WHEEL



DAILY FOOD JOURNAL

Nutrition Questionnaire



YES **NO**

Do you regularly read food labels?

Are you ever hungry again within 1 – 2 hours of eating?

Do you regularly eat breakfast?

How much water do you drink in a typical day?

How many times per day do you eat on average?

YES **NO**

Do you ever eat when you are not hungry?

If so, do you know why?





Are you responsible for the grocery shopping in your household?

How many times per week do you eat at restaurants (eat in or take out)?




NUTRITION JOURNAL

DATE: ___ / ___ / ___ WEEK: _____ DAY: _____

| MEAL TIME | FOOD CONSUMED | TOTAL CAL PER MEAL | TOTAL GRAMS PER MEAL | | |
|--|---------------|---------------------|-----------------------|--------------------|------|
| | | | Pro | Fat | Carb |
|  Breakfast | | | | | |
|  Mid Morning | | | | | |
|  Lunch | | | | | |
|  Mid Afternoon | | | | | |
|  Dinner | | | | | |
|  Nighttime | | | | | |
| TODAY I FEEL: <input type="checkbox"/> Energetic <input type="checkbox"/> Humorous <input type="checkbox"/> Depressed <input type="checkbox"/> Motivated <input type="checkbox"/> Patient <input type="checkbox"/> Overwhelmed <input type="checkbox"/> Joyful <input type="checkbox"/> Sad <input type="checkbox"/> Out of Control <input type="checkbox"/> Calm <input type="checkbox"/> Slow <input type="checkbox"/> Angry | | ENERGY LEVEL | TOTAL CALORIES | TOTAL GRAMS | |






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NOTES



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