

7 Day Food Log

Date: _____

Breakfast Time:	Snacks Time:	Lunch Time:	Snacks Time:	Dinner Time:	Snacks Time:	Beverages Time:

Irritability Prior to Eating? Y/N *Sleepy After Eating?* Y/N *Gas or Bloating?* Y/N *Bowel Movement?* Y/N
 Energy Level 0-10 _____ Mood 0-10 _____ Sleep 0-10 _____

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