Green Soul Holistics
Nutritional Consulting

Food Journal

Date: Mon. Tues. Wed. Thurs. Fri. Sat. Sun.

_____ Weight: _____

Number of 8 ounce glasses of water: 

Food & Drink: (everything, including tiny bites) *also indicate approximate amounts				
	Time	Food/Beverage	Mood Before	Mood After
Pre-Breakfast				
Breakfast				
Snack (mid-morning)				
Lunch				
Snack (mid-afternoon)				
Dinner				
Snack (evening)				
Medications / Supplements / Herbs / Other				

What did you notice (physically, mentally) after eating any of the above foods?

Digestion:	Number of Bowel Movements:	
	Description (size, colour, undigested food, etc.):	
	Other observations (gas/bloating, burping, acid stomach, etc.):	

Cravings:	☐ Salty ☐ Sweet ☐ Spicy ☐ Chocolate ☐ Coffee ☐ Alcohol ☐ Starches (breads, donuts, etc.)

Energy Level: (low energy) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (high energy)

Stress Level: (low stress) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 (high stress)

Mood(s) & Emotions: How would you describe your mood(s) today?		
Morning	**Afternoon**	**Evening**

Exercise #min/type	