Daily Record of Food Intake — *Your diet may be the key to better health.*

Each day, record all the items you eat and drink. Be sure to include the approximate amount of each item. When you have completed this form, return it to your doctor at Advance Health and Wellness Solutions for evaluation.

ADVANCE HEALTH AND WELLNESS SOLUTIONS
2000 S. Dixie Hwy., Second Floor, Suite 200
Coconut Grove, FL 33133
Phone: 786.360.6355
Email: doctorbert@gableshealer.com • www.gableshealer.com
www.advanceidealweightloss.com

Name: ______________________________

Day 1 *Date:* HOW WAS YOUR DAY? ☺ 😐

BREAKFAST Time:	*LUNCH* Time:	*DINNER* Time:
Meat and Dairy:		
Vegetables:		
Fruits:		
Grains, cereals and breads:		
Fats (butter, oil, etc.):		
Water intake (fl. oz.):		
Other drinks:		
Daily supplements:		
MIDMORNING SNACK Time:	*MIDDAY SNACK* Time:	*NIGHTTIME* Time:
Snack:		
Bowel movements (number and consistency):	*Hours of sleep:*	*Quality of sleep:* *(good)* *1 2 3 4 5* *(poor)*

Day 2 *Date:* HOW WAS YOUR DAY? ☺ 😐

BREAKFAST Time:	*LUNCH* Time:	*DINNER* Time:
Meat and Dairy:		
Vegetables:		
Fruits:		
Grains, cereals and breads:		
Fats (butter, oil, etc.):		
Water intake (fl. oz.):		
Other drinks:		
Daily supplements:		
MIDMORNING SNACK Time:	*MIDDAY SNACK* Time:	*NIGHTTIME* Time:
Snack:		
Bowel movements (number and consistency):	*Hours of sleep:*	*Quality of sleep:* *(good)* *1 2 3 4 5* *(poor)*

NOTE: *No candy, sweets, processed or refined products, margarine, coffee or alcohol should be consumed.*

Day 3 *Date:* HOW WAS YOUR DAY? ☺ 😐

BREAKFAST Time:	*LUNCH* Time:	*DINNER* Time:
Meat and Dairy:		
Vegetables:		
Fruits:		
Grains, cereals and breads:		
Fats (butter, oil, etc.):		
Water intake (fl. oz.):		
Other drinks:		
Daily supplements:		
MIDMORNING SNACK Time:	*MIDDAY SNACK* Time:	*NIGHTTIME* Time:
Snack:		
Bowel movements (number and consistency):	*Hours of sleep:*	*Quality of sleep:* *(good)* *1 2 3 4 5* *(poor)*

NOTE: *No candy, sweets, processed or refined products, margarine, coffee or alcohol should be consumed.*

Name: ______________________________

Day 4 Date: HOW WAS YOUR DAY? ☺ 😐

BREAKFAST Time:	*LUNCH* Time:	*DINNER* Time:
Meat and Dairy:		
Vegetables:		
Fruits:		
Grains, cereals and breads:		
Fats (butter, oil, etc.):		
Water intake (fl. oz.):		
Other drinks:		
Daily supplements:		
MIDMORNING SNACK Time:	*MIDDAY SNACK* Time:	*NIGHTTIME* Time:
Snack:		
Bowel movements (number and consistency):	*Hours of sleep:*	*Quality of sleep:* (good) 1 2 3 4 5 (poor)

Day 5 Date: HOW WAS YOUR DAY? ☺ 😐

BREAKFAST Time:	*LUNCH* Time:	*DINNER* Time:
Meat and Dairy:		
Vegetables:		
Fruits:		
Grains, cereals and breads:		
Fats (butter, oil, etc.):		
Water intake (fl. oz.):		
Other drinks:		
Daily supplements:		
MIDMORNING SNACK Time:	*MIDDAY SNACK* Time:	*NIGHTTIME* Time:
Snack:		
Bowel movements (number and consistency):	*Hours of sleep:*	*Quality of sleep:* (good) 1 2 3 4 5 (poor)

NOTE: *No candy, sweets, processed or refined products, margarine, coffee or alcohol should be consumed.*

Day 6 Date: HOW WAS YOUR DAY? ☺ 😐

BREAKFAST Time:	*LUNCH* Time:	*DINNER* Time:
Meat and Dairy:		
Vegetables:		
Fruits:		
Grains, cereals and breads:		
Fats (butter, oil, etc.):		
Water intake (fl. oz.):		
Other drinks:		
Daily supplements:		
MIDMORNING SNACK Time:	*MIDDAY SNACK* Time:	*NIGHTTIME* Time:
Snack:		
Bowel movements (number and consistency):	*Hours of sleep:*	*Quality of sleep:* (good) 1 2 3 4 5 (poor)

NOTE: *No candy, sweets, processed or refined products, margarine, coffee or alcohol should be consumed.*

Name: ____

Day 7 Date: HOW WAS YOUR DAY? ☺ 😐

BREAKFAST Time:	*LUNCH* Time:	*DINNER* Time:
Meat and Dairy:		
Vegetables:		
Fruits:		
Grains, cereals and breads:		
Fats (butter, oil, etc.):		
Water intake (fl. oz.):		
Other drinks:		
Daily supplements:		
MIDMORNING SNACK Time:	*MIDDAY SNACK* Time:	*NIGHTTIME* Time:
Snack:		
Bowel movements (number and consistency):	*Hours of sleep:*	*Quality of sleep:* *(good)* *1 2 3 4 5* *(poor)*

Day 8 Date: HOW WAS YOUR DAY? ☺ 😐

BREAKFAST Time:	*LUNCH* Time:	*DINNER* Time:
Meat and Dairy:		
Vegetables:		
Fruits:		
Grains, cereals and breads:		
Fats (butter, oil, etc.):		
Water intake (fl. oz.):		
Other drinks:		
Daily supplements:		
MIDMORNING SNACK Time:	*MIDDAY SNACK* Time:	*NIGHTTIME* Time:
Snack:		
Bowel movements (number and consistency):	*Hours of sleep:*	*Quality of sleep:* *(good)* *1 2 3 4 5* *(poor)*

NOTE: *No candy, sweets, processed or refined products, margarine, coffee or alcohol should be consumed.*

Day 9 Date: HOW WAS YOUR DAY? ☺ 😐

BREAKFAST Time:	*LUNCH* Time:	*DINNER* Time:
Meat and Dairy:		
Vegetables:		
Fruits:		
Grains, cereals and breads:		
Fats (butter, oil, etc.):		
Water intake (fl. oz.):		
Other drinks:		
Daily supplements:		
MIDMORNING SNACK Time:	*MIDDAY SNACK* Time:	*NIGHTTIME* Time:
Snack:		
Bowel movements (number and consistency):	*Hours of sleep:*	*Quality of sleep:* *(good)* *1 2 3 4 5* *(poor)*

NOTE: *No candy, sweets, processed or refined products, margarine, coffee or alcohol should be consumed.*

Name: ______________________________

Day 10 *Date:*		HOW WAS YOUR DAY? ☺ 😐
BREAKFAST Time:	*LUNCH* Time:	*DINNER* Time:
Meat and Dairy:		
Vegetables:		
Fruits:		
Grains, cereals and breads:		
Fats (butter, oil, etc.):		
Water intake (fl. oz.):		
Other drinks:		
Daily supplements:		
MIDMORNING SNACK Time:	*MIDDAY SNACK* Time:	*NIGHTTIME* Time:
Snack:		
Bowel movements (number and consistency):	*Hours of sleep:*	*Quality of sleep:* *(good)* *1 2 3 4 5* *(poor)*

Day 11 *Date:*		HOW WAS YOUR DAY? ☺ 😐
BREAKFAST Time:	*LUNCH* Time:	*DINNER* Time:
Meat and Dairy:		
Vegetables:		
Fruits:		
Grains, cereals and breads:		
Fats (butter, oil, etc.):		
Water intake (fl. oz.):		
Other drinks:		
Daily supplements:		
MIDMORNING SNACK Time:	*MIDDAY SNACK* Time:	*NIGHTTIME* Time:
Snack:		
Bowel movements (number and consistency):	*Hours of sleep:*	*Quality of sleep:* *(good)* *1 2 3 4 5* *(poor)*

NOTE: *No candy, sweets, processed or refined products, margarine, coffee or alcohol should be consumed.*

Day 12 *Date:*		HOW WAS YOUR DAY? ☺ 😐
BREAKFAST Time:	*LUNCH* Time:	*DINNER* Time:
Meat and Dairy:		
Vegetables:		
Fruits:		
Grains, cereals and breads:		
Fats (butter, oil, etc.):		
Water intake (fl. oz.):		
Other drinks:		
Daily supplements:		
MIDMORNING SNACK Time:	*MIDDAY SNACK* Time:	*NIGHTTIME* Time:
Snack:		
Bowel movements (number and consistency):	*Hours of sleep:*	*Quality of sleep:* *(good)* *1 2 3 4 5* *(poor)*

NOTE: *No candy, sweets, processed or refined products, margarine, coffee or alcohol should be consumed.*

Name: ____

Day 13 *Date:* HOW WAS YOUR DAY? ☺ 😐

BREAKFAST Time:	*LUNCH* Time:	*DINNER* Time:
Meat and Dairy:		
Vegetables:		
Fruits:		
Grains, cereals and breads:		
Fats (butter, oil, etc.):		
Water intake (fl. oz.):		
Other drinks:		
Daily supplements:		
MIDMORNING SNACK Time:	*MIDDAY SNACK* Time:	*NIGHTTIME* Time:
Snack:		
Bowel movements (number and consistency):	*Hours of sleep:*	*Quality of sleep:* *(good)* *1 2 3 4 5* *(poor)*

Day 14 *Date:* HOW WAS YOUR DAY? ☺ 😐

BREAKFAST Time:	*LUNCH* Time:	*DINNER* Time:
Meat and Dairy:		
Vegetables:		
Fruits:		
Grains, cereals and breads:		
Fats (butter, oil, etc.):		
Water intake (fl. oz.):		
Other drinks:		
Daily supplements:		
MIDMORNING SNACK Time:	*MIDDAY SNACK* Time:	*NIGHTTIME* Time:
Snack:		
Bowel movements (number and consistency):	*Hours of sleep:*	*Quality of sleep:* *(good)* *1 2 3 4 5* *(poor)*

NOTE: *No candy, sweets, processed or refined products, margarine, coffee or alcohol should be consumed.*

Day 15 *Date:* HOW WAS YOUR DAY? ☺ 😐

BREAKFAST Time:	*LUNCH* Time:	*DINNER* Time:
Meat and Dairy:		
Vegetables:		
Fruits:		
Grains, cereals and breads:		
Fats (butter, oil, etc.):		
Water intake (fl. oz.):		
Other drinks:		
Daily supplements:		
MIDMORNING SNACK Time:	*MIDDAY SNACK* Time:	*NIGHTTIME* Time:
Snack:		
Bowel movements (number and consistency):	*Hours of sleep:*	*Quality of sleep:* *(good)* *1 2 3 4 5* *(poor)*

NOTE: *No candy, sweets, processed or refined products, margarine, coffee or alcohol should be consumed.*

Name: ______________________________

Day 16 *Date:*		HOW WAS YOUR DAY? ☺ ☹
BREAKFAST *Time:*	*LUNCH* *Time:*	*DINNER* *Time:*
Meat and Dairy:		
Vegetables:		
Fruits:		
Grains, cereals and breads:		
Fats (butter, oil, etc.):		
Water intake (fl. oz.):		
Other drinks:		
Daily supplements:		
MIDMORNING SNACK *Time:*	*MIDDAY SNACK* *Time:*	*NIGHTTIME* *Time:*
Snack:		
Bowel movements *(number and consistency):*	*Hours of sleep:*	*Quality of sleep:* *(good)* *1 2 3 4 5* *(poor)*

Day 17 *Date:*		HOW WAS YOUR DAY? ☺ ☹
BREAKFAST *Time:*	*LUNCH* *Time:*	*DINNER* *Time:*
Meat and Dairy:		
Vegetables:		
Fruits:		
Grains, cereals and breads:		
Fats (butter, oil, etc.):		
Water intake (fl. oz.):		
Other drinks:		
Daily supplements:		
MIDMORNING SNACK *Time:*	*MIDDAY SNACK* *Time:*	*NIGHTTIME* *Time:*
Snack:		
Bowel movements *(number and consistency):*	*Hours of sleep:*	*Quality of sleep:* *(good)* *1 2 3 4 5* *(poor)*

NOTE: *No candy, sweets, processed or refined products, margarine, coffee or alcohol should be consumed.*

Day 18 *Date:*		HOW WAS YOUR DAY? ☺ ☹
BREAKFAST *Time:*	*LUNCH* *Time:*	*DINNER* *Time:*
Meat and Dairy:		
Vegetables:		
Fruits:		
Grains, cereals and breads:		
Fats (butter, oil, etc.):		
Water intake (fl. oz.):		
Other drinks:		
Daily supplements:		
MIDMORNING SNACK *Time:*	*MIDDAY SNACK* *Time:*	*NIGHTTIME* *Time:*
Snack:		
Bowel movements *(number and consistency):*	*Hours of sleep:*	*Quality of sleep:* *(good)* *1 2 3 4 5* *(poor)*

NOTE: *No candy, sweets, processed or refined products, margarine, coffee or alcohol should be consumed.*

Name: ____________________

Day 19 Date:

HOW WAS YOUR DAY? ☺ 😐

BREAKFAST Time:

LUNCH Time:

DINNER Time:

Meat and Dairy:

Vegetables:

Fruits:

Grains, cereals and breads:

Fats (butter, oil, etc.):

Water intake (fl. oz.):

Other drinks:

Daily supplements:

MIDMORNING SNACK Time:

MIDDAY SNACK Time:

NIGHTTIME Time:

Snack:

Bowel movements (number and consistency):

Hours of sleep:

Quality of sleep: *(good)* *1 2 3 4 5* *(poor)*

Day 20 Date:

HOW WAS YOUR DAY? ☺ 😐

BREAKFAST Time:

LUNCH Time:

DINNER Time:

Meat and Dairy:

Vegetables:

Fruits:

Grains, cereals and breads:

Fats (butter, oil, etc.):

Water intake (fl. oz.):

Other drinks:

Daily supplements:

MIDMORNING SNACK Time:

MIDDAY SNACK Time:

NIGHTTIME Time:

Snack:

Bowel movements (number and consistency):

Hours of sleep:

Quality of sleep: *(good)* *1 2 3 4 5* *(poor)*

NOTE: *No candy, sweets, processed or refined products, margarine, coffee or alcohol should be consumed.*

Day 21 Date:

HOW WAS YOUR DAY? ☺ 😐

BREAKFAST Time:

LUNCH Time:

DINNER Time:

Meat and Dairy:

Vegetables:

Fruits:

Grains, cereals and breads:

Fats (butter, oil, etc.):

Water intake (fl. oz.):

Other drinks:

Daily supplements:

MIDMORNING SNACK Time:

MIDDAY SNACK Time:

NIGHTTIME Time:

Snack:

Bowel movements (number and consistency):

Hours of sleep:

Quality of sleep: *(good)* *1 2 3 4 5* *(poor)*