



Diet, Nutrition, and Lifestyle Journal – 7 Day

Patient Name _____ Date _____

Food Plan Type: _____

Day 1

Day Event	Food & Drink Intake (include type, amount, brand)	Macronutrients (PFC) and Phytonutrients
Rising Time		
Breakfast Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Mid-AM Snack Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Lunch Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Mid-PM Snack Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Dinner Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
PM Snack Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Bed Time		

P: Proteins; **F:** Fats; **C:** Carbohydrates; **R:** Red; **O:** Orange; **Y:** Yellow; **G:** Green; **B/P/BL:** Blue/Purple/Black; **W/T/BR:** White/Tan/Brown

Sleep & Relaxation	Exercise & Movement	Stress	Relationships
Sleep Quantity: _____ (hours) Quality: <input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good Relaxation <input type="checkbox"/> Yes <input type="checkbox"/> No Type/Amount:	Type, Duration, & Intensity <input type="checkbox"/> Aerobic: <input type="checkbox"/> Strength: <input type="checkbox"/> Flexibility:	Stress Reduction Practices: Stressors:	Supporting: Non-supporting:

Mental	Emotional	Spiritual





Diet, Nutrition, and Lifestyle Journal – 7 Day

Patient Name _____ Date _____

Food Plan Type: _____

Day 2

Day Event	Food & Drink Intake (include type, amount, brand)	Macronutrients (PFC) and Phytonutrients
Rising Time		
Breakfast Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Mid-AM Snack Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Lunch Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Mid-PM Snack Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Dinner Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
PM Snack Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Bed Time		

P: Proteins; **F:** Fats; **C:** Carbohydrates; **R:** Red; **O:** Orange; **Y:** Yellow; **G:** Green; **B/P/BL:** Blue/Purple/Black; **W/T/BR:** White/Tan/Brown

Sleep & Relaxation	Exercise & Movement	Stress	Relationships
<p>Sleep Quantity: _____ (hours) Quality: <input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good</p> <p>Relaxation <input type="checkbox"/> Yes <input type="checkbox"/> No Type/Amount:</p>	<p>Type, Duration, & Intensity</p> <p><input type="checkbox"/> Aerobic:</p> <p><input type="checkbox"/> Strength:</p> <p><input type="checkbox"/> Flexibility:</p>	<p>Stress Reduction Practices:</p> <p>Stressors:</p>	<p>Supporting:</p> <p>Non-supporting:</p>

Mental	Emotional	Spiritual



Diet, Nutrition, and Lifestyle Journal – 7 Day

Patient Name _____ Date _____

Food Plan Type: _____

Day 3

Day Event	Food & Drink Intake (include type, amount, brand)	Macronutrients (PFC) and Phytonutrients
Rising Time		
Breakfast Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Mid-AM Snack Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Lunch Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Mid-PM Snack Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Dinner Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
PM Snack Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Bed Time		

P: Proteins; **F:** Fats; **C:** Carbohydrates; **R:** Red; **O:** Orange; **Y:** Yellow; **G:** Green; **B/P/BL:** Blue/Purple/Black; **W/T/BR:** White/Tan/Brown

Sleep & Relaxation	Exercise & Movement	Stress	Relationships
Sleep Quantity: _____ (hours) Quality: <input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good Relaxation <input type="checkbox"/> Yes <input type="checkbox"/> No Type/Amount:	Type, Duration, & Intensity <input type="checkbox"/> Aerobic: <input type="checkbox"/> Strength: <input type="checkbox"/> Flexibility:	Stress Reduction Practices: Stressors:	Supporting: Non-supporting:

Mental	Emotional	Spiritual



Diet, Nutrition, and Lifestyle Journal – 7 Day

Patient Name _____ Date _____

Food Plan Type: _____

Day 4

Day Event	Food & Drink Intake (include type, amount, brand)	Macronutrients (PFC) and Phytonutrients
Rising Time		
Breakfast Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Mid-AM Snack Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Lunch Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Mid-PM Snack Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Dinner Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
PM Snack Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Bed Time		

P: Proteins; **F:** Fats; **C:** Carbohydrates; **R:** Red; **O:** Orange; **Y:** Yellow; **G:** Green; **B/P/BL:** Blue/Purple/Black; **W/T/BR:** White/Tan/Brown

Sleep & Relaxation	Exercise & Movement	Stress	Relationships
Sleep Quantity: _____ (hours) Quality: <input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good Relaxation <input type="checkbox"/> Yes <input type="checkbox"/> No Type/Amount:	Type, Duration, & Intensity <input type="checkbox"/> Aerobic: <input type="checkbox"/> Strength: <input type="checkbox"/> Flexibility:	Stress Reduction Practices: Stressors:	Supporting: Non-supporting:

Mental	Emotional	Spiritual



Diet, Nutrition, and Lifestyle Journal – 7 Day

Patient Name _____ Date _____

Food Plan Type: _____

Day 5

Day Event	Food & Drink Intake (include type, amount, brand)	Macronutrients (PFC) and Phytonutrients
Rising Time		
Breakfast Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Mid-AM Snack Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Lunch Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Mid-PM Snack Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Dinner Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
PM Snack Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Bed Time		

P: Proteins; **F:** Fats; **C:** Carbohydrates; **R:** Red; **O:** Orange; **Y:** Yellow; **G:** Green; **B/P/BL:** Blue/Purple/Black; **W/T/BR:** White/Tan/Brown

Sleep & Relaxation	Exercise & Movement	Stress	Relationships
<p>Sleep Quantity: _____ (hours) Quality: <input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good</p> <p>Relaxation <input type="checkbox"/> Yes <input type="checkbox"/> No Type/Amount:</p>	<p>Type, Duration, & Intensity</p> <p><input type="checkbox"/> Aerobic:</p> <p><input type="checkbox"/> Strength:</p> <p><input type="checkbox"/> Flexibility:</p>	<p>Stress Reduction Practices:</p> <p>Stressors:</p>	<p>Supporting:</p> <p>Non-supporting:</p>

Mental	Emotional	Spiritual





Diet, Nutrition, and Lifestyle Journal – 7 Day

Patient Name _____ Date _____

Food Plan Type: _____

Day 6

Day Event	Food & Drink Intake (include type, amount, brand)	Macronutrients (PFC) and Phytonutrients
Rising Time		
Breakfast Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Mid-AM Snack Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Lunch Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Mid-PM Snack Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Dinner Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
PM Snack Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Bed Time		

P: Proteins; **F:** Fats; **C:** Carbohydrates; **R:** Red; **O:** Orange; **Y:** Yellow; **G:** Green; **B/P/BL:** Blue/Purple/Black; **W/T/BR:** White/Tan/Brown

Sleep & Relaxation	Exercise & Movement	Stress	Relationships
<p>Sleep Quantity: _____ (hours) Quality: <input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good</p> <p>Relaxation <input type="checkbox"/> Yes <input type="checkbox"/> No Type/Amount:</p>	<p>Type, Duration, & Intensity</p> <p><input type="checkbox"/> Aerobic:</p> <p><input type="checkbox"/> Strength:</p> <p><input type="checkbox"/> Flexibility:</p>	<p>Stress Reduction Practices:</p> <p>Stressors:</p>	<p>Supporting:</p> <p>Non-supporting:</p>

Mental	Emotional	Spiritual



Diet, Nutrition, and Lifestyle Journal – 7 Day

Patient Name _____ Date _____

Food Plan Type: _____

Day 7

Day Event	Food & Drink Intake (include type, amount, brand)	Macronutrients (PFC) and Phytonutrients
Rising Time		
Breakfast Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Mid-AM Snack Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Lunch Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Mid-PM Snack Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Dinner Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
PM Snack Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Bed Time		

P: Proteins; **F:** Fats; **C:** Carbohydrates; **R:** Red; **O:** Orange; **Y:** Yellow; **G:** Green; **B/P/BL:** Blue/Purple/Black; **W/T/BR:** White/Tan/Brown

Sleep & Relaxation	Exercise & Movement	Stress	Relationships
<p>Sleep Quantity: _____ (hours) Quality: <input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good</p> <p>Relaxation <input type="checkbox"/> Yes <input type="checkbox"/> No Type/Amount:</p>	<p>Type, Duration, & Intensity</p> <p><input type="checkbox"/> Aerobic:</p> <p><input type="checkbox"/> Strength:</p> <p><input type="checkbox"/> Flexibility:</p>	<p>Stress Reduction Practices:</p> <p>Stressors:</p>	<p>Supporting:</p> <p>Non-supporting:</p>

Mental	Emotional	Spiritual

