Robinsong Health Low Carb Clinic-

Instructions for Filling Out Food and Drink Journal

Please record all food and drink consumed. This includes coffee and tea (indicate what is taken in the coffee or tea- sugar, milk etc), water and alcohol. Please be as detailed as possible. If you have diabetes and you take a glucose tablet because of low sugar, please record this as well.

Please eat as you normally would. Do not try to eat “better” or change any aspect while completing the food journal. Remember, no one will be judging you for this. It is simply a tool and will be more effective if it is accurate.

There is a space for recording snacks between meals and after supper. Do NOT feel you NEED to eat a snack. If you normally would not have a snack, then don’t.

The comments section is to describe how you feel before or after meals. For example, dizzy, hungry, tired etc… This is more important once you have started the program as it allows us to make changes based on how you are feeling, however feel free to add comments if you have any. If there are none it is fine to leave this blank.

BG is for blood glucose (blood sugars). These may be tested before or two hours after meals by persons with diabetes. Otherwise, there is no need to complete this.

If you monitor your blood pressure please include those readings at the bottom of page 2. If you do not monitor your blood pressure that is fine to leave blank.

Ideally, you record your food and drink intake on two weekdays and one weekend day since food patterns change for some people from weekday to weekend. Three days of journals is enough, however we have included extra pages in case you wish to record a few more days.

Please either record as you go during the day (best) or at the end of the day. Don’t try to remember three days’ worth of food and record it that way. It’s just not very accurate!

ROBINSONG HEALTH LOW CARB CLINIC FOOD JOURNAL

***BG is blood glucose or blood sugars- for persons with diabetes- if testing already**

Notes or comments- can write how you are feeling- hungry, dizzy, tired etc… or leave blank.

Date:_____

	Description and amount of food and drinks
Breakfast Time:_____	_____ _____
Notes or comments	_____ *BG before breakfast: ____ BG 2 hrs after breakfast:_____
Snack Time:_____	_____
Notes or comments	_____
Lunch Time:_____	_____ _____ _____ _____
Notes or comments	_____ BG before lunch: ____ BG 2 hrs after lunch:_____
Snack Time:_____	_____
Notes or comments	_____

	Description and amount of food and drinks
Supper Time:_____	_____ _____ _____ _____
Notes or comments	_____ BG before supper: ____ BG 2 hrs after supper:_____
Snack Time:_____	_____
Notes	_____

Stress level today on a scale of 0 to 10: _____

Pain today on a scale of 0 to 10: _____

Number of hours of sleep last night: ____

Energy level today on a scale of 0 to 10: ____

Optional readings

Blood pressure:_____ time taken: _____

Blood pressure:_____ time taken: _____