Food & Feelings Week

WEEK OF _____ NAME _____

	Mon	Tue	Wed	Thu	Fri	Sat	Sun
	_____	_____	_____	_____	_____	_____	_____
Breakfast							
Lunch							
Dinner							
Snacks							
Drinks							

How you felt that evening

Tick one box for each day, short to tall: None · Small · Noticeable · Disruptive.

	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Bloating							
Gas							
Cramping or pain							
Diarrhea							
Constipation							
_____							
Notes							

Fill the food in as you go, and how you felt that evening.

Fieldnote fieldnote.health