MY DIET CHECKUP

24-Hour Food Intake Record

Please write down everything you eat or drink, including water, no matter how little. Show amounts actually eaten.

Name: ______________________ Age:_______ Weight _______ Height: _____ BMI: ______ Date: _______________

Address: ______________________ City: ____________________ State: _____ Zip: ____________________

Email: ______________________ Telephone (Optional): ____________________ Fax: ____________________

Breakfast		**Lunch**		**Dinner**		**Dietitian's Notes**	
Time:		***Time:***		***Time:***		Item	Met/Under/Over
Amt	Food	Amt	Food	Amt	Food	Kcal	
						CHO	
						Pro	
						Fat	
						Fiber	
						Water	
						Vit A	
						FA	
						Vit C	
Snacks: Morning		Snacks: Afternoon		Snacks: Night		Vit D	
						Ca	
						Fe	
						Other	

How active are you?

___ Quite active (regular exercise, gym, sports, etc)

___ Moderately active (housework, some walking, job that involves frequent movement, etc.)

___ Hardly active (sitting or lying down mostly, couch potato, sedentary job, inactive retiree)

Do you have any restrictions on exercising? ______ Yes ______ No If yes, specify: ____________________

Check any of the following that apply to you: ❑ Overweight ❑ Obese ❑ Diabetes ❑ High Blood Pressure ❑ High Cholesterol ❑ Other

- ❑ My current health and/or nutrition goal is:
- ❑ My biggest problem is:
- ❑ I am committed to doing what is necessary to lose the weight. ___Yes ___ No
- ❑ I think I lack the necessary commitment and motivation to succeed at this time. ___Yes ___ No

Please double check your entries and email the completed form to: drdorene@dailydietguide.com. *If you have a medical condition requiring medical attention, it is important that you get a referral from your personal physician. (Email me if you have any questions.)*

Email: **drdorene@dailydietguide.com** **Telephone: 305-663-4251**

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