NATURAL PRACTICES

Daily Diet

Name of Patient: _____

Date: _____

VEGETARIAN / MEAT EATER / VEGAN

Breakfast

Mid A.M.

Lunch

Mid P.M.

Dinner

Snacks

Cravings / Binges

Any foods not eaten?

FLUID INTAKE (in cups) ☐ Water ☐ Tea ☐ Coffee ☐ Other (inc. alcohol)

Current Medication (prescribed and vitamins / minerals)