Dudley Chiropractic, Acupuncture and Functional Medicine
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4-Day Food Log

Complete this packet by hand, or fill out the same log online at www.dudleychiro.com/food-log-mooresville-nc.html

Name _____ **Date started** _____

Bring the completed packet to your next visit, or scan it and email it to the office.

How to fill this out

Record everything you eat and drink.
Meals, snacks, coffee, soda, alcohol, and water. Include butter, dressing, sauce, and added sugar, since these contribute as much as the food underneath them.

Write each entry as you go.
Reconstructing a full day from memory at bedtime produces an incomplete record. Entering a meal within an hour of eating keeps the detail accurate.

Note how you felt afterward.
Your energy, digestion, and appetite in the one to three hours after a meal are what connect a specific food to a specific symptom.

Rate each day before bed.
Four numbers covering energy, digestion, mood, and sleep. Rate the sleep from the night before.

Eat the way you normally eat.
This packet documents your current pattern rather than evaluating it. Changing how you eat during these four days removes the information we are looking for.

Estimating portions without measuring

Palm of your hand	3 to 4 oz of meat or fish	**Your closed fist**	1 cup of rice or pasta
Cupped hand	1 oz of nuts or dry cereal	**Thumb tip**	1 tablespoon of oil or butter
Baseball	A medium fruit or large potato	**Golf ball**	2 tablespoons of nut butter

Estimates are acceptable throughout. Exact weights are not required for the log to be useful.

Day 1

Date _____ Day of week _____ Name _____

BREAKFAST

Time _____

How you felt after: ☐ Good ☐ Tired ☐ Bloated ☐ Hungry soon ☐ Heartburn Other _____

LUNCH

Time _____

How you felt after: ☐ Good ☐ Tired ☐ Bloated ☐ Hungry soon ☐ Heartburn Other _____

DINNER

Time _____

How you felt after: ☐ Good ☐ Tired ☐ Bloated ☐ Hungry soon ☐ Heartburn Other _____

SNACKS

Time _____

How you felt after: ☐ Good ☐ Tired ☐ Bloated ☐ Hungry soon ☐ Heartburn Other _____

BEVERAGES

coffee, tea, soda, juice, alcohol

WATER

fill in one glass per 8 oz ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ More _____

END OF DAY

1 = poor, 5 = excellent

Energy 1 2 3 4 5

Digestion 1 2 3 4 5

Mood 1 2 3 4 5

Sleep last night 1 2 3 4 5

Bowel movement today: ☐ None ☐ 1 ☐ 2 ☐ 3 or more ☐ Loose ☐ Hard ☐ Normal

NOTES

stress, exercise, medications, supplements, anything unusual

Day 2

Date _____ Day of week _____ Name _____

BREAKFAST

Time _____

How you felt after: ☐ Good ☐ Tired ☐ Bloated ☐ Hungry soon ☐ Heartburn Other _____

LUNCH

Time _____

How you felt after: ☐ Good ☐ Tired ☐ Bloated ☐ Hungry soon ☐ Heartburn Other _____

DINNER

Time _____

How you felt after: ☐ Good ☐ Tired ☐ Bloated ☐ Hungry soon ☐ Heartburn Other _____

SNACKS

Time _____

How you felt after: ☐ Good ☐ Tired ☐ Bloated ☐ Hungry soon ☐ Heartburn Other _____

BEVERAGES

coffee, tea, soda, juice, alcohol

WATER

fill in one glass per 8 oz ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ More _____

END OF DAY

1 = poor, 5 = excellent

Energy 1 2 3 4 5

Digestion 1 2 3 4 5

Mood 1 2 3 4 5

Sleep last night 1 2 3 4 5

Bowel movement today: ☐ None ☐ 1 ☐ 2 ☐ 3 or more ☐ Loose ☐ Hard ☐ Normal

NOTES

stress, exercise, medications, supplements, anything unusual

Day 3

Date _____ Day of week _____ Name _____

BREAKFAST

Time _____

How you felt after: ☐ Good ☐ Tired ☐ Bloated ☐ Hungry soon ☐ Heartburn Other _____

LUNCH

Time _____

How you felt after: ☐ Good ☐ Tired ☐ Bloated ☐ Hungry soon ☐ Heartburn Other _____

DINNER

Time _____

How you felt after: ☐ Good ☐ Tired ☐ Bloated ☐ Hungry soon ☐ Heartburn Other _____

SNACKS

Time _____

How you felt after: ☐ Good ☐ Tired ☐ Bloated ☐ Hungry soon ☐ Heartburn Other _____

BEVERAGES

coffee, tea, soda, juice, alcohol

WATER

fill in one glass per 8 oz ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ More _____

END OF DAY

1 = poor, 5 = excellent

Energy	1	2	3	4	5	**Digestion**	1	2	3	4	5
Mood	1	2	3	4	5	**Sleep last night**	1	2	3	4	5

Bowel movement today: ☐ None ☐ 1 ☐ 2 ☐ 3 or more ☐ Loose ☐ Hard ☐ Normal

NOTES

stress, exercise, medications, supplements, anything unusual

Day 4

Date _____ Day of week _____ Name _____

BREAKFAST

Time _____

How you felt after: ☐ Good ☐ Tired ☐ Bloated ☐ Hungry soon ☐ Heartburn Other _____

LUNCH

Time _____

How you felt after: ☐ Good ☐ Tired ☐ Bloated ☐ Hungry soon ☐ Heartburn Other _____

DINNER

Time _____

How you felt after: ☐ Good ☐ Tired ☐ Bloated ☐ Hungry soon ☐ Heartburn Other _____

SNACKS

Time _____

How you felt after: ☐ Good ☐ Tired ☐ Bloated ☐ Hungry soon ☐ Heartburn Other _____

BEVERAGES

coffee, tea, soda, juice, alcohol

WATER

fill in one glass per 8 oz ○ ○ ○ ○ ○ ○ ○ ○ ○ ○ More _____

END OF DAY

1 = poor, 5 = excellent

Energy 1 2 3 4 5

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Sleep last night 1 2 3 4 5

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NOTES

stress, exercise, medications, supplements, anything unusual