Daily Food Sensitivity Log

Patient Information

Name: _____

Address: _____

Phone No.: _____ Sex: ____ Date of Birth: _____

General Health: _____

Instructions: On the left side, keep a detailed record of all foods, drinks and medications consumed throughout the day. On the right side, keep a detailed record of changing moods and health, including fatigue, nausea, bloating, gas and irritability. Use the space between the columns to draw lines linking possible trigger foods to relavent effects. Discuss these records with a physician before drawing any conclusions.

FOOD, DRINKS, MEDICATIONS	TIME

TIME	MOOD, HEALTH, SYMPTOMS

NOTES AND CONCLUSIONS:

Signature: _____ Date: _____