NAME: **DATES:**

Time of Day	Day	Minutes Spent Eating	Meals / Snacks / Drinks - List Each Food	How Much of Each?	Hungry? Yes / No	Standing (S) Sitting (s), or Laying (L)?	Activity while Eating?	Where are you Eating?	Eating (with Whom)?
Ex. 9a	Sun	3	White bread & jam	1 slice/1tsp	Yes	s	TV	Den	spouse
9.15a	Sun	10	2 % Milk	8 oz.	No	S	Walking	Outside	alone