



THE LITTLE
FLOWER
WELLNESS & NUTRITION

Diet, Nutrition, and Lifestyle Journal- 3 Day

Patient Name _____ Date _____

Food Plan Type: _____

Day 1

Day Event	Food & Drink Intake (include type, amount, brand)	Macronutrients (PFC) and Phytonutrients
Rising Time		
Breakfast Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Mid-AM Snack Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Lunch Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Mid-PM Snack Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Dinner Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
PM Snack Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Bed Time		

P: Proteins; F: Fats; C: Carbohydrates; R: Red; O: Orange; Y: Yellow; G: Green; B/P/BL: Blue/Purple/Black; W/T/BR: White/Tan/Brown

Sleep & Relaxation	Exercise & Movement	Stress	Relationships
Sleep Quantity: _____(hours) Quality: <input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good Relaxation <input type="checkbox"/> Yes <input type="checkbox"/> No Type/Amount:	Type, Duration, & Intensity <input type="checkbox"/> Aerobic: <input type="checkbox"/> Strength: <input type="checkbox"/> Flexibility:	Stress Reduction Practices: Stressors:	Supporting: Non-supporting:

Mental	Emotional	Spiritual



Patient Name _____ Date _____

Food Plan Type: _____

Day 2

Day Event	Food & Drink Intake (include type, amount, brand)	Macronutrients (PFC) and Phytonutrients
Rising Time		
Breakfast Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Mid-AM Snack Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Lunch Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Mid-PM Snack Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Dinner Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
PM Snack Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Bed Time		

P: Proteins; **F:** Fats; **C:** Carbohydrates; **R:** Red; **O:** Orange; **Y:** Yellow; **G:** Green; **B/P/BL:** Blue/Purple/Black; **W/T/BR:** White/Tan/Brown

Sleep & Relaxation	Exercise & Movement	Stress	Relationships
Sleep Quantity: _____(hours) Quality: <input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good Relaxation <input type="checkbox"/> Yes <input type="checkbox"/> No Type/Amount:	Type, Duration, & Intensity <input type="checkbox"/> Aerobic: <input type="checkbox"/> Strength: <input type="checkbox"/> Flexibility:	Stress Reduction Practices: Stressors:	Supporting: Non-supporting:

Mental	Emotional	Spiritual



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Food Plan Type: _____

Day 3

Day Event	Food & Drink Intake (include type, amount, brand)	Macronutrients (PFC) and Phytonutrients
Rising Time		
Breakfast Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Mid-AM Snack Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Lunch Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Mid-PM Snack Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Dinner Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
PM Snack Time		_____ P _____ F _____ C <input type="checkbox"/> R <input type="checkbox"/> O <input type="checkbox"/> Y <input type="checkbox"/> G <input type="checkbox"/> B/P/BL <input type="checkbox"/> W/T/BR
Bed Time		

P: Proteins; **F:** Fats; **C:** Carbohydrates; **R:** Red; **O:** Orange; **Y:** Yellow; **G:** Green; **B/P/BL:** Blue/Purple/Black; **W/T/BR:** White/Tan/Brown

Sleep & Relaxation	Exercise & Movement	Stress	Relationships
Sleep Quantity: _____(hours) Quality: <input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good Relaxation <input type="checkbox"/> Yes <input type="checkbox"/> No Type/Amount:	Type, Duration, & Intensity <input type="checkbox"/> Aerobic: <input type="checkbox"/> Strength: <input type="checkbox"/> Flexibility:	Stress Reduction Practices: Stressors:	Supporting: Non-supporting:

Mental	Emotional	Spiritual