



Patient's Name: \_\_\_\_\_ USC 10-digit #: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
mm / dd / yy

Please check the day of the week that applies to this journal:  Monday  Tuesday  Wednesday  Thursday  Friday  Saturday  Sunday

TIME	FOOD / BEVERAGE / and QUANTITY	
<b>BREAKFAST</b>		
<input type="checkbox"/> AM <input type="checkbox"/> PM		
<input type="checkbox"/> AM <input type="checkbox"/> PM	<b>Snack</b>	
<b>LUNCH</b>		
<input type="checkbox"/> AM <input type="checkbox"/> PM		
<input type="checkbox"/> AM <input type="checkbox"/> PM	<b>Snack</b>	
<b>DINNER</b>		
<input type="checkbox"/> AM <input type="checkbox"/> PM		
<input type="checkbox"/> AM <input type="checkbox"/> PM	<b>Snack</b>	
Hours of Sleep Last Night:		Caffeine Intake: (i.e., soda, coffee, etc.)
		Water Intake: (i.e., bottle, glass, etc.)
Exercise Activity (types of physical activity performed during the day)		Duration (i.e., ran for 30 minutes)