EATING DISORDERS PROGRAM - MEAL JOURNAL

Name: _____ Date: _____

Time	Breakfast	Amount/Description of food eaten	Water/Beverages	H/S Scale
	Dairy			
	Protein			
	Starch			
	Fruit/Juice			
	Vege/Salad			
	Fats			
	Snack:			
	Lunch	**Amount/Description of food eaten**	**Water/Beverages**	**H/S Scale**
	Dairy			
	Protein			
	Starch			
	Fruit/Juice			
	Vege/Salad			
	Fats			
	Dessert			
	Snack:			
	Dinner	**Amount/Description of food eaten**	**Water/Beverages**	**H/S Scale**
	Dairy			
	Protein			
	Starch			
	Fruit/Juice			
	Vege/Salad			
	Fats			
	Dessert			
	Snack:			

Met expectation of meal plan/meal level Yes/No (If no, describe variance on back)
B (#): _____ P (#): _____ Exercise (type/amount): _____
Alcohol/Drugs/Diet Pills/Laxatives/Caffeine: _____
Weighing self or other behaviors: _____
Did you take your medications as prescribed by your doctor: Yes ___ No ___ N/A ___

Today's Goal and/or Affirmation

In the spaces below, write about your mood, thoughts, and feelings at mealtimes. Also, describe and discuss variances from the meal plan and try to identify the triggering events and feelings that affect your eating.

Breakfast

Lunch

Dinner

Snacks

Variances (if you did not meet your meal plan please explain)