FRANCESCA ELDRIDGE HEALTH

Date:
Name:

	DAY 1	DAY 2	DAY 3
BREAKFAST **Time** **How taken?** (e.g. at table, in car, at desk)			
LUNCH **Time** **How taken?**			
DINNER **Time** **How Taken?**			
FLUIDS **Time**			
SNACKS **Time**			

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Did you / your child experience any bloating, gas, discomfort, headaches, fatigue, tantrums, irritability, loose bowel motions, constipation, sneezing, itching, skin rashes, runny nose, sweating or any other physical or emotional symptoms during the 3 days? Please note the timing.

Which fats or oils do you cook with?

Which spreads do you use? (butter, margarine, something else....?)

What are your pots, pans and oven dishes made from?

Do you have a water bottle or reusable coffee cup? What are these made of?

Please list all supplements you are currently taking, noting the brand, product and daily dose you take here.

SUPPLEMENT	BRAND/PRODUCT NAME	DAILY DOSE	REASON TAKING

Thank you for taking the time to complete your Food Diary, this helps us maximize the time available for your first appointment.

All information you have provided will remain strictly confidential.

FRANCESCA ELDRIDGE HEALTH

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