

Food 'n' Mood

Name: _____ Date: _____ Day: _____ Time: _____ Day: _____ Date: _____ Page: _____

Check off 10 good points of eating:

Time	Place	Food/ Beverage	How often	How healthy	How often

What's your favorite snack? _____

Why do you eat it? _____

What's your favorite drink? _____

Why do you drink it? _____

What's your favorite fruit? _____

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