

NAME: _____ TODAY'S DATE: _____

- 1 Are you pregnant? Yes No
- 2 Are you breastfeeding? Yes No
- 3 Do you take nutritional supplements? Yes No
- 4 How much money did you spend on food last month? _____
- 5 How much time do you spend doing physical activity? Less than 30 minutes each day
 30 to 60 minutes each day
 More than 60 minutes each day
- 6 List everything you had to eat and drink in the last 24 hours. Give as much detail as possible below.

MEAL TYPE		SERVING ABBREVIATIONS	
1 = Morning	4 = Afternoon	tbsp = Tablespoon	c = Cup
2 = Midmorning	5 = Evening	tsp = Teaspoon	lb = Pound
3 = Noon	6 = Late Evening	oz = Ounce	sl = Slice

MEAL TYPE	FOOD AND DRINKS List all foods and beverages. List all ingredients in mixed dishes. List how cooked (fried, boiled, or broiled).	AMOUNT EATEN / DRANK
1	MORNING MEAL / SNACK	
2	MIDMORNING MEAL	
3	NOON MEAL	

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4	AFTERNOON MEAL / SNACK	
5	EVENING MEAL	
6	LATE EVENING MEAL / SNACK	

FOR OFFICE USE ONLY

<input type="checkbox"/> Entry	<input type="checkbox"/> Exit	ID
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**FCS-2252**

For more information, contact your county Extension office. Visit www.aces.edu/directory.

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