Client's 24-Hour Diet Recall

Name: _____

Date Taken: _____

Pregnant: ☐ Yes ☐ No Nursing: ☐ Yes ☐ No

Takeing Nutritional Supplements: ☐ Yes ☐ No

Activity Level:

- ☐ Less than 30 min.
- ☐ 30-60 minutes
- ☐ More than 60 min.

Amount spent on food last month: _____

MEAL TYPE

1 = Morning
2 = Mid-Morning
3 = Noon
4 = Afternoon
5 = Evening
6 = Late Evening

SERVING ABBEVIATIONS

Tablespoon = TBSP
Cup = c
Teaspoon = tsp
Pound = lb
Ounce = oz
Slice = sl

List what you had to eat and drink in the last 24 hours? (Be thorough.)

Food and beverages consumed. Describe in detail. List one food per line.	AMOUNT	MEAL TYPE