This form helps us understand how you are eating. Please complete this form after you have finished this meal. If you need help, let us know.

1. List all drinks on your tray; this includes juice, tea/coffee, milk, drink supplements, etc.
2. Place an ‘X’ in the circle to indicate how much you consumed of each beverage
3. For the food on your tray, place an ‘X’ in the circle to indicate how much you ate overall; this includes the main dish, side dishes, soup, bread, dessert
4. List any food or beverages you are saving to eat at a later time
5. Turn the page over and answer the remaining questions

<table>
<thead>
<tr>
<th>What meal is this?</th>
<th>Breakfast</th>
<th>Lunch</th>
<th>Supper</th>
</tr>
</thead>
<tbody>
<tr>
<td>What and how much did you drink?</td>
<td>0% I drank none</td>
<td>25%</td>
<td>50%</td>
</tr>
<tr>
<td>Example: Milk</td>
<td>❚</td>
<td>❚</td>
<td>❚</td>
</tr>
</tbody>
</table>

How much of all the food on your tray did you eat?

<table>
<thead>
<tr>
<th>0% I ate none</th>
<th>25%</th>
<th>50%</th>
<th>75%</th>
<th>100% I ate all</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>❚</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please list any items (food or beverages) being saved for later:

______________________________

Please turn over
How was your appetite at this meal?

- Very good/Good
- Less than usual

Why was your appetite less than usual?

- I was not interested in eating
- I had nausea/vomiting
- I was tired
- I had pain
- I ate other foods and was not hungry
- No specific reason
- Other: ____________________________________________
  ____________________________________________
  ____________________________________________

Other comments to share with us about your food intake:

___________________________________________________________________________________________________________
___________________________________________________________________________________________________________
___________________________________________________________________________________________________________
___________________________________________________________________________________________________________
___________________________________________________________________________________________________________
___________________________________________________________________________________________________________
___________________________________________________________________________________________________________

Who completed this form?

- Patient
- Family/Friend/Volunteer
- Staff

Did you have any challenges at this meal?

- I needed help to sit up to eat
- I needed help opening food packages
- I needed help to eat and/or drink
- I did not like the food
- I had problems chewing/swallowing
- I was not allowed to eat because I am having a test today
- I did not get what I had ordered (if selective menu)
- The environment was not appetizing
- Other: ____________________________________________
  ____________________________________________
  ____________________________________________
  I had no challenges