Intermittent Fasting Schedule

PATIENT INFORMATION

Name: _____ Date of Birth: _____ dd / mm / yyyy

Gender: _____ Height: _____

Weight: _____

Medical History:

Current Medications:

HEALTH INFORMATION

Blood Pressure: _____ Cholesterol Levels: _____

Blood Sugar Levels: _____

Allergies:

Instructions for Using the Intermittent Fasting Schedule Template: Fasting Window: The client should abstain from food during the specified fasting window. Eating Window: Consume meals and snacks within the designated eating window. Meal Details: Follow the meal suggestions provided for each day, ensuring a balanced intake of proteins, carbohydrates, and healthy fats. Hydration Recommendations: Stay hydrated by consuming water, herbal tea, or other non-caloric beverages throughout both fasting and eating windows. Additional Notes: If the client experiences any adverse effects or has concerns, contact the healthcare provider immediately.

Notes/Observations:

INTERMITTENT FASTING SCHEDULE

Monday Fasting Window: _____ Monday Eating Window: _____

Monday Meal 1: _____ Monday Meal 2: _____

Monday Meal 3: _____ Monday Snacks: _____

Monday Hydration: _____ Tuesday Fasting Window: _____

Tuesday Eating Window: _____ Tuesday Meal 1: _____

Tuesday Meal 2: _____ Tuesday Meal 3: _____

Tuesday Snacks: _____ Tuesday Hydration: _____

Wednesday Fasting Window: _____ Wednesday Eating Window: _____

Wednesday Meal 1: _____ Wednesday Meal 2: _____

Wednesday Meal 3: _____ Wednesday Snacks: _____

Wednesday Hydration: _____ Thursday Fasting Window: _____

Thursday Eating Window: _____ Thursday Meal 1: _____

Thursday Meal 2: _____ Thursday Meal 3: _____

Thursday Snacks: _____ Thursday Hydration: _____

Friday Fasting Window: _____ Friday Eating Window: _____

Friday Meal 1: _____ Friday Meal 2: _____

Friday Meal 3: _____ Friday Snacks: _____

Friday Hydration: _____ Saturday Fasting Window: _____

Saturday Eating Window: _____ Saturday Meal 1: _____

Saturday Meal 2: _____ Saturday Meal 3: _____

Saturday Snacks: _____ Saturday Hydration: _____

Sunday Fasting Window: _____ Sunday Eating Window: _____

Sunday Meal 1: _____ Sunday Meal 2: _____

Sunday Meal 3: _____ Sunday Snacks: _____

Sunday Hydration: _____

Doctor's Signature:

Doctor's Name: _____ Date: _____ dd / mm / yyyy