

Intermittent Fasting Schedule

PATIENT INFORMATION

Name:

Date of Birth:

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:

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

Notes/Observations:

Intermittent Fasting Schedule

Day	Fasting Window	Eating Window	Meal 1	Meal 2	Meal 3	Snacks	Hydration
Monday							
Tuesday							
Wednesday							

Day	Fasting Window	Eating Window	Meal 1	Meal 2	Meal 3	Snacks	Hydration
Thursday							
Friday							
Saturday							
Sunday							

Doctor's Signature:

Doctor's Name:

Date: