



DAY: _____
 DATE: / /

MORNING

Sleep hours: _____ grade (a-f): _____ Medication: _____

BP: _____ pH: _____ Blood Sugar: _____ Supplements: _____

Food	Notes: Time of day, how did you like your food, how did you feel, how hungry were you before/after eating, etc.
Breakfast	
Snack	
Lunch	
Snack	
Dinner	
Snack	
Exercise	Notes: What exercise did you do? Duration, intensity, with whom, how did you feel before/after?

EVENING

Mood / Stress Level : _____ Water:

Gratitude: List three things you are grateful for today _____

