

Date: \_\_\_\_\_

Weight \_\_\_\_\_

Sleep Quality: \_\_\_\_\_

Movement: \_\_\_\_\_

Today's One Thing: \_\_\_\_\_

What I Ate Today: (time stamp)

Breakfast/Time: \_\_\_\_\_

Snack/Time: \_\_\_\_\_

Lunch/Time: \_\_\_\_\_

Snack/Time: \_\_\_\_\_

Dinner/Time: \_\_\_\_\_

Snack/Time: \_\_\_\_\_

My Bodies Feedback

Hunger: \_\_\_\_\_

Energy: \_\_\_\_\_

Cravings: \_\_\_\_\_

Mood: \_\_\_\_\_

General Thoughts: \_\_\_\_\_