



Mind and Body Fitness Connections

Owner: Gwyn Davis, LMT, CNMT
 www.mindandbodyfitness.net
 zenzoneokc@gmail.com
 (405) 535-2505

DAILY FOOD AND EXERCISE JOURNAL

Name:

Date:

Please log 3 to 5 days of consecutive food and lifestyle habits. Once complete please email the forms to Gwyn at zenzoneokc@gmail.com

FOOD JOURNAL		
Time	Food Consumed	Feeling After Eating – Immediate up to Two Hours <i>(check all that apply)</i>
		<input type="checkbox"/> Satisfied <input type="checkbox"/> Mental Clarity <input type="checkbox"/> Good Energy Between Meals <input type="checkbox"/> No Cravings <input type="checkbox"/> Headache <input type="checkbox"/> Other <input type="checkbox"/> Sleepy <input type="checkbox"/> Crave Fat/Protein <input type="checkbox"/> Crave Sweets <input type="checkbox"/> Crave Coffee/Tea <input type="checkbox"/> Quickly Hungry <input type="checkbox"/> Full but Hungry <input type="checkbox"/> Sluggish <input type="checkbox"/> Jittery <input type="checkbox"/> Nervous Energy
		<input type="checkbox"/> Satisfied <input type="checkbox"/> Mental Clarity <input type="checkbox"/> Good Energy Between Meals <input type="checkbox"/> No Cravings <input type="checkbox"/> Headache <input type="checkbox"/> Other <input type="checkbox"/> Sleepy <input type="checkbox"/> Crave Fat/Protein <input type="checkbox"/> Crave Sweets <input type="checkbox"/> Crave Coffee/Tea <input type="checkbox"/> Quickly Hungry <input type="checkbox"/> Full but Hungry <input type="checkbox"/> Sluggish <input type="checkbox"/> Jittery <input type="checkbox"/> Nervous Energy
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EXERCISE				
Cardio				
Type of Exercise	Time	Duration		
Flexibility				
Type (select one)			Duration	
<input type="checkbox"/> Foam Rolling <input type="checkbox"/> Corrective Home Program <input type="checkbox"/> Other				
Working in Exercise				
Type	Style		Duration	
Yoga				
Qigong				
Resistance Training				
Muscles Trained		# of Exercises	Sets	Reps
<input type="checkbox"/> Total Body <input type="checkbox"/> Split				
<input type="checkbox"/> Total Body <input type="checkbox"/> Split				
Zone Exercises				
Zone # / Exercise Zone	Number of Sets	Number of Reps		
<i>Example: Zone 1/Superman</i>	<i>1</i>	<i>5</i>		



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MEDICATION & SUPPLEMENTS

Name	Time	Amount

SLEEP		
Bed Time	Wake Time	Upon Waking
		<input type="checkbox"/> Rested <input type="checkbox"/> Not Rested

WATER
Ounces Consumed

TEMPERATURE AND HEART RATE			
Timeframe	Time Reading Taken	Temperature (°F)	Heart Rate (beats per minute)
Upon Waking			
30 Minutes After Breakfast			
30 Minutes after Lunch			

FEMALE CYCLE	
Day of Month	
Notes	

ELIMINATION		
Number of Times	Observations	
<input type="checkbox"/> Once <input type="checkbox"/> Twice <input type="checkbox"/> More than twice <input type="checkbox"/> None	<input type="checkbox"/> Normal <input type="checkbox"/> Hard to pass <input type="checkbox"/> Loose <input type="checkbox"/> Pale Colored	<input type="checkbox"/> Food Particles Seen <input type="checkbox"/> Foul Smelling <input type="checkbox"/> Other



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NOTES

Please add any additional notes in the space below.

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