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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Name:** | | Enter Name | | | | | | | | **Date:** | | | | | Select 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](mailto:zenzoneokc@gmail.com) | | | | | | | | | | | | | | | | | | | | | | | |
| **FOOD JOURNAL** | | | | | | | | | | | | | | | | | | | | | | | |
| Time | Food Consumed | | | | | | Feeling After Eating – Immediate up to Two Hours  *(check all that apply)* | | | | | | | | | | | | | | | | |
| Enter Time | Enter Food Consumed | | | | | | Satisfied  Mental Clarity  Good Energy Between Meals  No Cravings  Headache | | | | | | Sleepy  Crave Fat/Protein  Crave Sweets  Crave Coffee/Tea  Quickly Hungry | | | | | | | | | Full but Hungry  Sluggish  Jittery  Nervous Energy | |
| Other Enter Other Feeling After Eating | | | | | | | | | | | | | | | | |
| Enter Time | Enter Food Consumed | | | | | | Satisfied  Mental Clarity  Good Energy Between Meals  No Cravings  Headache | | | | | | Sleepy  Crave Fat/Protein  Crave Sweets  Crave Coffee/Tea  Quickly Hungry | | | | | | | | | Full but Hungry  Sluggish  Jittery  Nervous Energy | |
| Other Enter Other Feeling After Eating | | | | | | | | | | | | | | | | |
| Enter Time | Enter Food Consumed | | | | | | Satisfied  Mental Clarity  Good Energy Between Meals  No Cravings  Headache | | | | | | Sleepy  Crave Fat/Protein  Crave Sweets  Crave Coffee/Tea  Quickly Hungry | | | | | | | | | Full but Hungry  Sluggish  Jittery  Nervous Energy | |
| Other Enter Other Feeling After Eating | | | | | | | | | | | | | | | | |
| Enter Time | Enter Food Consumed | | | | | | Satisfied  Mental Clarity  Good Energy Between Meals  No Cravings  Headache | | | | | | Sleepy  Crave Fat/Protein  Crave Sweets  Crave Coffee/Tea  Quickly Hungry | | | | | | | | | Full but Hungry  Sluggish  Jittery  Nervous Energy | |
| Other Enter Other Feeling After Eating | | | | | | | | | | | | | | | | |
| Enter Time | Enter Food Consumed | | | | | | Satisfied  Mental Clarity  Good Energy Between Meals  No Cravings  Headache | | | | | | Sleepy  Crave Fat/Protein  Crave Sweets  Crave Coffee/Tea  Quickly Hungry | | | | | | | | | Full but Hungry  Sluggish  Jittery  Nervous Energy | |
| Other Enter Other Feeling After Eating | | | | | | | | | | | | | | | | |
| Enter Time | Enter Food Consumed | | | | | | Satisfied  Mental Clarity  Good Energy Between Meals  No Cravings  Headache | | | | | | Sleepy  Crave Fat/Protein  Crave Sweets  Crave Coffee/Tea  Quickly Hungry | | | | | | | | | Full but Hungry  Sluggish  Jittery  Nervous Energy | |
| Other Enter Other Feeling After Eating | | | | | | | | | | | | | | | | |
| Enter Time | Enter Food Consumed | | | | | | Satisfied  Mental Clarity  Good Energy Between Meals  No Cravings  Headache | | | | | | Sleepy  Crave Fat/Protein  Crave Sweets  Crave Coffee/Tea  Quickly Hungry | | | | | | | | | Full but Hungry  Sluggish  Jittery  Nervous Energy | |
| Other Enter Other Feeling After Eating | | | | | | | | | | | | | | | | |
| **EXERCISE** | | | | | | | | | | | | | | | | | | | | | | | | |
| **Cardio** | | | | | | | | | | | | | | | | | | | | | | | | |
| **Type of Exercise** | | | | | | | | | | | | | | | | **Time** | | | | **Duration** | | | | |
| Enter type of cardio exercise | | | | | | | | | | | | | | | | Enter Time | | | | Enter Duration | | | | |
| Enter type of cardio exercise | | | | | | | | | | | | | | | | Enter Time | | | | Enter Duration | | | | |
| **Flexibility** | | | | | | | | | | | | | | | | | | | | | | | | |
| **Type *(select one)*** | | | | | | | | | | | | | | | | | | | | **Duration** | | | | |
| Foam Rolling | | | | | | Corrective Home Program | | | | | Other  Enter other type of flexibility | | | | | | | | | Enter Duration | | | | |
| **Working in Exercise** | | | | | | | | | | | | | | | | | | | | | | | | |
| **Type** | | | | **Style** | | | | | | | | | | | | | | | | | **Duration** | | | |
| Yoga | | | | Enter Style of Yoga | | | | | | | | | | | | | | | | | Enter Duration | | | |
| Qigong | | | | Enter Style of Qigong | | | | | | | | | | | | | | | | | Enter Duration | | | |
| **Resistance Training** | | | | | | | | | | | | | | | | | | | | | | | | |
| **Muscles Trained** | | | | | | | | | | | | | | **# of Exercises** | | | | | **Sets** | | | | **Reps** | |
| Total Body | | | Split Enter Muscles Trained | | | | | | | | | | | Enter # | | | | | Enter Sets | | | | Enter Reps | |
| Total Body | | | SplitEnter Muscles Trained | | | | | | | | | | | Enter # | | | | | Enter Sets | | | | Enter Reps | |
| **Zone Exercises** | | | | | | | | | | | | | | | | | | | | | | | | |
| **Zone # / Exercise Zone** | | | | | | | | **Number of Sets** | | | | | | | | | **Number of Reps** | | | | | | | |
| *Example: Zone 1/Superman* | | | | | | | | *1* | | | | | | | | | *5* | | | | | | | |
| Enter Zone #/Exercise Zone | | | | | | | | Enter Sets | | | | | | | | | Enter Reps | | | | | | | |
| Enter Zone #/Exercise Zone | | | | | | | | Enter Sets | | | | | | | | | Enter Reps | | | | | | | |
| Enter Zone #/Exercise Zone | | | | | | | | Enter Sets | | | | | | | | | Enter Reps | | | | | | | |
| Enter Zone #/Exercise Zone | | | | | | | | Enter Sets | | | | | | | | | Enter Reps | | | | | | | |
| Enter Zone #/Exercise Zone | | | | | | | | Enter Sets | | | | | | | | | Enter Reps | | | | | | | |
| Enter Zone #/Exercise Zone | | | | | | | | Enter Sets | | | | | | | | | Enter Reps | | | | | | | |
| Enter Zone #/Exercise Zone | | | | | | | | Enter Sets | | | | | | | | | Enter Reps | | | | | | | |
| Enter Zone #/Exercise Zone | | | | | | | | Enter Sets | | | | | | | | | Enter Reps | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | |
| **MEDICATION & SUPPLEMENTS** | | | | | | | | | | | | | | | | | | | | | | | | |
| **Name** | | | | | | | | | | | | | | | | | | | **Time** | | | | **Amount** | |
| Enter name of medication or supplement | | | | | | | | | | | | | | | | | | | Enter Time | | | | Enter Amount | |
| Enter name of medication or supplement | | | | | | | | | | | | | | | | | | | Enter Time | | | | Enter Amount | |
| Enter name of medication or supplement | | | | | | | | | | | | | | | | | | | Enter Time | | | | Enter Amount | |
| Enter name of medication or supplement | | | | | | | | | | | | | | | | | | | Enter Time | | | | Enter Amount | |
| Enter name of medication or supplement | | | | | | | | | | | | | | | | | | | Enter Time | | | | Enter Amount | |
| Enter name of medication or supplement | | | | | | | | | | | | | | | | | | | Enter Time | | | | Enter Amount | |
| Enter name of medication or supplement | | | | | | | | | | | | | | | | | | | Enter Time | | | | Enter Amount | |
|  | | | | | | | | | | | | | | | | | |  |  | | | | | |
| **SLEEP** | | | | | | | | | | | | | | | | | |  | **WATER** | | | | | |
| **Bed Time** | | | | | **Wake Time** | | | | **Upon Waking** | | | | | | | | |  | **Ounces Consumed** | | | | | |
| Enter Time | | | | | Enter Time | | | | Rested | | | Not Rested | | | | | |  | Enter Amount | | | | | |

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| --- | --- | --- | --- | --- | --- | --- |
| **TEMPERATURE AND HEART RATE** | | | |  | **FEMALE CYCLE** | |
| **Timeframe** | **Time Reading Taken** | **Temperature (°F)** | **Heart Rate**  **(beats per minute)** |  | **Day of Month** | Enter Day |
| **Notes** | |
| Upon Waking | Enter Time | Enter Temp | Enter Heart Rate |  | Enter Notes for any related issues, such as cramping, mood swings, etc. | |
| 30 Minutes After Breakfast | Enter Time | Enter Temp | Enter Heart Rate |  |
| 30 Minutes after Lunch | Enter Time | Enter Temp | Enter Heart Rate |  |

|  |  |  |
| --- | --- | --- |
| **ELIMINATION** | | |
| **Number of Times** | **Observations** | |
| Once  Twice  More than twice  None | Normal  Hard to pass  Loose  Pale Colored | Food Particles Seen  Foul Smelling  Other Enter Other |

|  |
| --- |
| **NOTES** |
| ***Please add any additional notes in the space below.*** |
| Enter Notes |