|  |  |  |  |
| --- | --- | --- | --- |
| **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 |
| **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 | [ ]  OtherEnter 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 |

|  |  |  |
| --- | --- | --- |
| **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 |