Daily Journal

BloodNUTRITION™

Date ____________________

Sleep

How many hours did you sleep last night? ______________________________________

Did you have any issues during your sleep? (woke up to use the bathroom, thirsty, tossing, turning, trouble falling asleep, etc) ____

____

____

____

Nutrition

MORNING

- Breakfast ____

  ____
- Beverages ____

  ____
- How did you feel after your meal? ______________________________________

  ____

  ____

  ____
- Snacks ____

  ____
- Beverages ____

  ____

MIDDAY

- Lunch ____

  ____
- Beverages ____

  ____
- How did you feel after your meal? ______________________________________

  ____

  ____

  ____

Daily Journal

EVENING

- Snacks ____
  ____
- Beverages ____
  ____
- How did you feel after your meal? ______________________________
  ____
  ____
  ____

BEFORE BEDTIME

- Snacks ____
  ____
- Beverages ____
  ____

Exercise

Did you exercise? ☐ Yes ☐ No

If yes, please check appropriate activity.

☐ yoga
☐ walking/running
☐ sports
☐ weights
other (please explain) ______________________________________
____

Please describe any other issues you had today (any physical, mental, emotional stress):

____
____
____
____

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