

NUTRITION LOG



Name:

DOW:

Date:

Wake-up time:

Bed time:

Exercise: Please record in your Cardio Log

Vitamins:

Meal #1: _____ Time: _____ _____ _____ _____ Where did you eat? _____	Y N lean protein <input type="checkbox"/> <input type="checkbox"/> vegetable <input type="checkbox"/> <input type="checkbox"/> healthy fat <input type="checkbox"/> <input type="checkbox"/> carbohydrate <input type="checkbox"/> <input type="checkbox"/> water <input type="checkbox"/> <input type="checkbox"/>	How are you feeling? _____ _____ _____ _____
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Meal #2: _____ Time: _____ _____ _____ _____ Where did you eat? _____	Y N lean protein <input type="checkbox"/> <input type="checkbox"/> vegetable <input type="checkbox"/> <input type="checkbox"/> healthy fat <input type="checkbox"/> <input type="checkbox"/> carbohydrate <input type="checkbox"/> <input type="checkbox"/> water <input type="checkbox"/> <input type="checkbox"/>	How are you feeling? _____ _____ _____ _____
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Meal #3: _____ Time: _____ _____ _____ _____ Where did you eat? _____	Y N lean protein <input type="checkbox"/> <input type="checkbox"/> vegetable <input type="checkbox"/> <input type="checkbox"/> healthy fat <input type="checkbox"/> <input type="checkbox"/> carbohydrate <input type="checkbox"/> <input type="checkbox"/> water <input type="checkbox"/> <input type="checkbox"/>	How are you feeling? _____ _____ _____ _____
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Meal #4: _____ Time: _____ _____ _____ _____ Where did you eat? _____	Y N lean protein <input type="checkbox"/> <input type="checkbox"/> vegetable <input type="checkbox"/> <input type="checkbox"/> healthy fat <input type="checkbox"/> <input type="checkbox"/> carbohydrate <input type="checkbox"/> <input type="checkbox"/> water <input type="checkbox"/> <input type="checkbox"/>	How are you feeling? _____ _____ _____ _____
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Meal #5: _____ Time: _____ _____ _____ _____ Where did you eat? _____	Y N lean protein <input type="checkbox"/> <input type="checkbox"/> vegetable <input type="checkbox"/> <input type="checkbox"/> healthy fat <input type="checkbox"/> <input type="checkbox"/> carbohydrate <input type="checkbox"/> <input type="checkbox"/> water <input type="checkbox"/> <input type="checkbox"/>	How are you feeling? _____ _____ _____ _____
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Meal #6: _____ Time: _____ _____ _____ _____ Where did you eat? _____	Y N lean protein <input type="checkbox"/> <input type="checkbox"/> vegetable <input type="checkbox"/> <input type="checkbox"/> healthy fat <input type="checkbox"/> <input type="checkbox"/> carbohydrate <input type="checkbox"/> <input type="checkbox"/> water <input type="checkbox"/> <input type="checkbox"/>	How are you feeling? _____ _____ _____ _____
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