Be Fab – Be You LLC
Newsletter + Free Session: www.BeFabBeYou.com
FREE Health Assessment: www.IDLife4you2.com
Events/Updates: Facebook.com/BeFabBeYouWellness
770.835.5490 // info@BeFabBeYou.com

Food and Wellness Journal: Guidelines

Name:
Start Date:

Guidelines to Completing Food and Wellness Journal:

1) Be honest. This information is invaluable as it serves as the main vehicle to learn about how foods and activity level affect your body and mind. We will use this information to help you achieve your short and long term health goals

2) Record everything you eat and drink immediately

3) Record time you eat and drink immediately

4) Record amount of foods and beverages--i.e., number of cups, slices, ounces, tsp, Tbsp, etc

5) Record your sleep pattern: time you wake-up and go to bed and number of times you wake up during the night

6) Record your bowel movements

7) Record GI (gastrointestinal) symptoms

8) Record daily level of physical activity (i.e., brisk walk, strength training, etc.), time of day and length of workout. In addition, record any short burst exercises done throughout the day. Burst exercises are short in duration (energy/focus/d-stressor activities). Examples are flight of stairs, squats, push-ups, etc

9) Record your energy level

10) Record any muscle and joint pain. If you feel pain performing physical activity, stop and discuss it with your trainer

11) Record any of stress techniques you applied during the day

12) Describe any emotional symptoms throughout the day: cravings, angry, sad, frustrated, happy, starving, bored, depressed, irritable, anxiety, cramps, poor concentration, stress, etc

13) Describe how you felt while you ate (angry, sad, happy, nervous, starving, bored, etc) in the notes session of meals

Be Fab – Be You LLC
Newsletter + Free Session: www.BeFabBeYou.com
FREE Health Assessment: www.IDLife4you2.com
Events/Updates: Facebook.com/BeFabBeYouWellness
770.835.5490 // info@BeFabBeYou.com

EXAMPLE: HOW TO COMPLETE THE FOOD & WELLNESS JOURNAL

Name: XXX
Date: 4/1/2015

Meal Type (Bkft, Lunch, Snack, Dinner)	**Time**	**Food Description**	**Amount** (# oz, cups, tsp, Tbsp, slices, pieces, etc)	**Notes (i.e., hungry, satisfied, bored)**
Bkft	*7am*	*greek yogurt, plain, 2% fat*	*1/2 c*	*woke up hungry*
Bkft	*7am*	*blueberries*	*1/2 c*	*woke up hungry*
Bkft	*7am*	*walnuts*	*3x*	*woke up hungry*
lunch	*11:30am*	*salad: spinach*	*5 cups*	*still hungry after lunch. Gassy after eating*
lunch	*11:30am*	*salad: egg*	*1x*	*still hungry after lunch. Gassy after eating*
lunch	*11:30am*	*salad: chicken*	*3 oz*	*still hungry after lunch. Gassy after eating*
lunch	*11:30am*	*salad: extra virgin olive oil*	*1 Tbsp*	*still hungry after lunch. Gassy after eating*
snack	*3:30pm*	*apple, almod butter*	*1/2x, 1 Tbsp*	
dinner	*6pm*	*Chicken wheat bread sandwish: 2 slices bread, slice of cheddar cheese, approx 3oz chicken, 2 slices tomatoes, 3 leaves lettuce, 1 tbps mayo, mustard, 1/2 avocado*	*1x*	*was starving*
snack	*9pm*	*medium chocolate cookie*	*1x*	*feel bloated afterwards*
Beverages:		***Water:***	*4 c*	*with lemon*
	9am + 3pm	***Tea (herbal, black, green):***	*2 c*	*herbal*
	7am + 6pm	***Coffee:***	*2 c*	*w/ sugar and cream*
		Soda/carbonated beverages:		
	9pm	***Alcoholic and other beverages:***	*1 glass*	*red wine*

Sleep Behavior:			
Woke up:	*645am*	# Times Woke Up During Night:	*2*
Bed Time:	*10pm*	Woke Up Feeling (rested, tired, etc):	*tired*

Energy Level (i.e., Excellent, Fair, Poor)		**Bowel Movement**	**G.I. Symptoms**	
Morning:	*fair*	Morning: *Yes*	Bloating:	When? *after dinner*
Afternoon:	*poor*	Afternoon:	Gas:	When? *throughout day*
Before Physical Activity:	*fair*	Night: *Yes*	Heartburn:	
After Physical Activity:	*excellent*	None:	Reflux:	
			Other: Describe	

Physical Activity:			
Description (1):	*treadmill walking approx 2 miles*	***Time & Length:*** ***i.e., 10am, 30min***	*7:30am, 30min*
Description (2):	*7min workout, stretching*	***Time & Length:*** ***i.e., 10am, 30min***	*8pm, 12min*
Daily Short Burst Activities:	*2x 5 flight of stairs, 2x 5 push-ups*	***Stress Mgmt : Techniques Applied During Day?***	*none*
Muscle Pain: Describe:	*sore harmstrings and abs*		
Joint Pain: Describe:	*right knee felt uncomfortable after walk*		

Other Emotions					
Angry:__X____	Anxiety:__X__	Sugar Craving After Meal? __X____	Afternoon?____X_____Varies?_____	Hot Flash:_____	Hungry After Meal?_____
Salt Cravings:_____	Depression:_____	Poor concentration:_____	Brain Fog:__X___	Overwhelmed:___X __	Stress:_____ Irritable/Frustrated:_____
Other emotions/notes:	*work has been really stressful. Cravings in the afternoon.*				

Food & Wellness Journal - Be Fab - Be You!

Name: _____
Date: _____

Newsletter + Free Session: www.BeFabBeYou.com
FREE Health Assessment: www.IDLife4you2.com
770.835.5490 // info@BeFabBeYou.com

Meal Type (Bkft, Lunch, Snack, Dinner)	**Time**	**Food Description**	**Amount** (# oz, cups, tsp, Tbsp, slices, pieces, etc)	**Notes (i.e., hungry, satisfied, bored)**
Beverages:		**Water:**		
		Tea (herbal, black, green):		
		Coffee:		
		Soda/carbonated beverages:		
		Alcoholic and other beverages:		

Sleep Behavior:			
Woke up:		# Times Woke Up During Night:	
Bed Time:		Woke Up Feeling (rested, tired, etc):	

Energy Level (i.e., Excellent, Fair, Poor)		**Bowel Movement ('Yes' when applies)**	**G.I. Symptoms**	
Morning:		Morning:	Bloating:	When?
Afternoon:		Afternoon:	Gas:	When?
Before Physical Activity:		Night:	Heartburn:	When?
After Physical Activity:		None:	Reflux:	When?
			Other: Describe	

Physical Activity:			
Description (1):		**Time & Length:** *i.e., 10am, 30min*	
Description (2):		**Time & Length:** *i.e., 10am, 30min*	
Daily Short Burst Activities:		***Stress Mgmt : Techniques Applied During Day?***	
Muscle Pain: Describe:			
Joint Pain: Describe:			

Other Emotions

Angry:_____ Anxiety:_____ Sugar Craving After Meal? _____ Afternoon?_____Varies?_____ Hot Flash:_____ Hungry After Meal?____

Poor Concentration:_____ Depression:_____ Salt Cravings:_____ Brain Fog:_____ Overwhelmed:_____ Stress:_____ Irritable/Frustrated:_____

Other emotions/notes:

Food & Wellness Journal - Be Fab - Be You!

Name: ________________
Date: ________________

Newsletter + Free Session: www.BeFabBeYou.com
FREE Health Assessment: www.IDLife4you2.com
770.835.5490 // info@BeFabBeYou.com

Meal Type (Bkft, Lunch, Snack, Dinner)	**Time**	**Food Description**	**Amount** (# oz, cups, tsp, Tbsp, slices, pieces, etc)	**Notes (i.e., hungry, satisfied, bored)**
Beverages:		**Water:**		
		Tea (herbal, black, green):		
		Coffee:		
		Soda/carbonated beverages:		
		Alcoholic and other beverages:		

Sleep Behavior:			
Woke up:		# Times Woke Up During Night:	
Bed Time:		Woke Up Feeling (rested, tired, etc):	

Energy Level (i.e., Excellent, Fair, Poor)		**Bowel Movement ('Yes' when applies)**	**G.I. Symptoms**	
Morning:		Morning:	Bloating:	When?
Afternoon:		Afternoon:	Gas:	When?
Before Physical Activity:		Night:	Heartburn:	When?
After Physical Activity:		None:	Reflux:	When?
			Other: Describe	

Physical Activity:			
Description (1):		**Time & Length:** *i.e., 10am, 30min*	
Description (2):		**Time & Length:** *i.e., 10am, 30min*	
Daily Short Burst Activities:		***Stress Mgmt :* Techniques Applied During Day?**	
Muscle Pain: Describe:			
Joint Pain: Describe:			

Other Emotions

Angry:______ Anxiety:_________ Sugar Craving After Meal? ______ Afternoon?________Varies?_______ Hot Flash:_______ Hungry After Meal?____

Poor Concentration:______ Depression:______ Salt Cravings:________ Brain Fog:________ Overwhelmed:________ Stress:__________ Irritable/Frustrated:_____

Other emotions/notes:

Food & Wellness Journal - Be Fab - Be You!

Name: _____
Date: _____

Newsletter + Free Session: www.BeFabBeYou.com
FREE Health Assessment: www.IDLife4you2.com
770.835.5490 // info@BeFabBeYou.com

Meal Type (Bkft, Lunch, Snack, Dinner)	**Time**	**Food Description**	**Amount** (# oz, cups, tsp, Tbsp, slices, pieces, etc)	**Notes (i.e., hungry, satisfied, bored)**
Beverages:		**Water:**		
		Tea (herbal, black, green):		
		Coffee:		
		Soda/carbonated beverages:		
		Alcoholic and other beverages:		

Sleep Behavior:			
Woke up:		# Times Woke Up During Night:	
Bed Time:		Woke Up Feeling (rested, tired, etc):	

Energy Level (i.e., Excellent, Fair, Poor)		**Bowel Movement ('Yes' when applies)**	**G.I. Symptoms**	
Morning:		Morning:	Bloating:	When?
Afternoon:		Afternoon:	Gas:	When?
Before Physical Activity:		Night:	Heartburn:	When?
After Physical Activity:		None:	Reflux:	When?
			Other: Describe	

Physical Activity:			
Description (1):		**Time & Length:** *i.e., 10am, 30min*	
Description (2):		**Time & Length:** *i.e., 10am, 30min*	
Daily Short Burst Activities:		***Stress Mgmt : Techniques Applied During Day?***	
Muscle Pain: Describe:			
Joint Pain: Describe:			

Other Emotions

Angry:_____ Anxiety:_____ Sugar Craving After Meal? _____ Afternoon?_____Varies?_____ Hot Flash:_____ Hungry After Meal?____

Poor Concentration:_____ Depression:_____ Salt Cravings:_____ Brain Fog:_____ Overwhelmed:_____ Stress:_____ Irritable/Frustrated:_____

Other emotions/notes:

Food & Wellness Journal - Be Fab - Be You!

Name: _____
Date: _____

Newsletter + Free Session: www.BeFabBeYou.com
FREE Health Assessment: www.IDLife4you2.com
770.835.5490 // info@BeFabBeYou.com

Meal Type (Bkft, Lunch, Snack, Dinner)	**Time**	**Food Description**	**Amount** (# oz, cups, tsp, Tbsp, slices, pieces, etc)	**Notes (i.e., hungry, satisfied, bored)**
Beverages:		**Water:**		
		Tea (herbal, black, green):		
		Coffee:		
		Soda/carbonated beverages:		
		Alcoholic and other beverages:		

Sleep Behavior:			
Woke up:		# Times Woke Up During Night:	
Bed Time:		Woke Up Feeling (rested, tired, etc):	

Energy Level (i.e., Excellent, Fair, Poor)		**Bowel Movement ('Yes' when applies)**	**G.I. Symptoms**	
Morning:		Morning:	Bloating:	When?
Afternoon:		Afternoon:	Gas:	When?
Before Physical Activity:		Night:	Heartburn:	When?
After Physical Activity:		None:	Reflux:	When?
			Other: Describe	

Physical Activity:			
Description (1):		**Time & Length:** *i.e., 10am, 30min*	
Description (2):		**Time & Length:** *i.e., 10am, 30min*	
Daily Short Burst Activities:		***Stress Mgmt : Techniques Applied During Day?***	
Muscle Pain: Describe:			
Joint Pain: Describe:			

Other Emotions

Angry:_____ Anxiety:_____ Sugar Craving After Meal? _____ Afternoon?_____Varies?_____ Hot Flash:_____ Hungry After Meal?____

Poor Concentration:_____ Depression:_____ Salt Cravings:_____ Brain Fog:_____ Overwhelmed:_____ Stress:_____ Irritable/Frustrated:_____

Other emotions/notes:

Food & Wellness Journal - Be Fab - Be You!

Name: ________________
Date: ________________

Newsletter + Free Session: www.BeFabBeYou.com
FREE Health Assessment: www.IDLife4you2.com
770.835.5490 // info@BeFabBeYou.com

Meal Type (Bkft, Lunch, Snack, Dinner)	**Time**	**Food Description**	**Amount** (# oz, cups, tsp, Tbsp, slices, pieces, etc)	**Notes (i.e., hungry, satisfied, bored)**
Beverages:		**Water:**		
		Tea (herbal, black, green):		
		Coffee:		
		Soda/carbonated beverages:		
		Alcoholic and other beverages:		

Sleep Behavior:			
Woke up:		# Times Woke Up During Night:	
Bed Time:		Woke Up Feeling (rested, tired, etc):	

Energy Level (i.e., Excellent, Fair, Poor)		**Bowel Movement ('Yes' when applies)**	**G.I. Symptoms**	
Morning:		Morning:	Bloating:	When?
Afternoon:		Afternoon:	Gas:	When?
Before Physical Activity:		Night:	Heartburn:	When?
After Physical Activity:		None:	Reflux:	When?
			Other: Describe	

Physical Activity:			
Description (1):		**Time & Length:** ***i.e., 10am, 30min***	
Description (2):		**Time & Length:** ***i.e., 10am, 30min***	
Daily Short Burst Activities:		***Stress Mgmt :*** ***Techniques Applied During Day?***	
Muscle Pain: Describe:			
Joint Pain: Describe:			

Other Emotions

Angry:______ Anxiety:_________ Sugar Craving After Meal? ______ Afternoon?_________Varies?_______ Hot Flash:_______ Hungry After Meal?____

Poor Concentration:______ Depression:______ Salt Cravings:________ Brain Fog:________ Overwhelmed:________ Stress:__________ Irritable/Frustrated:_____

Other emotions/notes:	

Food & Wellness Journal - Be Fab - Be You!

Name: _____
Date: _____

Newsletter + Free Session: www.BeFabBeYou.com
FREE Health Assessment: www.IDLife4you2.com
770.835.5490 // info@BeFabBeYou.com

Meal Type (Bkft, Lunch, Snack, Dinner)	**Time**	**Food Description**	**Amount** (# oz, cups, tsp, Tbsp, slices, pieces, etc)	**Notes (i.e., hungry, satisfied, bored)**
Beverages:		**Water:**		
		Tea (herbal, black, green):		
		Coffee:		
		Soda/carbonated beverages:		
		Alcoholic and other beverages:		

Sleep Behavior:			
Woke up:		# Times Woke Up During Night:	
Bed Time:		Woke Up Feeling (rested, tired, etc):	

Energy Level (i.e., Excellent, Fair, Poor)		**Bowel Movement ('Yes' when applies)**	**G.I. Symptoms**	
Morning:		Morning:	Bloating:	When?
Afternoon:		Afternoon:	Gas:	When?
Before Physical Activity:		Night:	Heartburn:	When?
After Physical Activity:		None:	Reflux:	When?
			Other: Describe	

Physical Activity:			
Description (1):		**Time & Length:** *i.e., 10am, 30min*	
Description (2):		**Time & Length:** *i.e., 10am, 30min*	
Daily Short Burst Activities:		***Stress Mgmt : Techniques Applied During Day?***	
Muscle Pain: Describe:			
Joint Pain: Describe:			

Other Emotions

Angry:_____ Anxiety:_____ Sugar Craving After Meal? _____ Afternoon?_____Varies?_____ Hot Flash:_____ Hungry After Meal?____

Poor Concentration:_____ Depression:_____ Salt Cravings:_____ Brain Fog:_____ Overwhelmed:_____ Stress:_____ Irritable/Frustrated:_____

Other emotions/notes:

Food & Wellness Journal - Be Fab - Be You!

Name: ________________
Date: ________________

Newsletter + Free Session: www.BeFabBeYou.com
FREE Health Assessment: www.IDLife4you2.com
770.835.5490 // info@BeFabBeYou.com

Meal Type (Bkft, Lunch, Snack, Dinner)	**Time**	**Food Description**	**Amount** (# oz, cups, tsp, Tbsp, slices, pieces, etc)	**Notes (i.e., hungry, satisfied, bored)**
Beverages:		**Water:**		
		Tea (herbal, black, green):		
		Coffee:		
		Soda/carbonated beverages:		
		Alcoholic and other beverages:		

Sleep Behavior:			
Woke up:		# Times Woke Up During Night:	
Bed Time:		Woke Up Feeling (rested, tired, etc):	

Energy Level (i.e., Excellent, Fair, Poor)		**Bowel Movement ('Yes' when applies)**	**G.I. Symptoms**	
Morning:		Morning:	Bloating:	When?
Afternoon:		Afternoon:	Gas:	When?
Before Physical Activity:		Night:	Heartburn:	When?
After Physical Activity:		None:	Reflux:	When?
			Other: Describe	

Physical Activity:			
Description (1):		**Time & Length:** ***i.e., 10am, 30min***	
Description (2):		**Time & Length:** ***i.e., 10am, 30min***	
Daily Short Burst Activities:		***Stress Mgmt :*** ***Techniques Applied During Day?***	
Muscle Pain: Describe:			
Joint Pain: Describe:			

Other Emotions

Angry:______ Anxiety:_________ Sugar Craving After Meal? ______ Afternoon?_________Varies?_______ Hot Flash:_______ Hungry After Meal?____

Poor Concentration:______ Depression:______ Salt Cravings:________ Brain Fog:________ Overwhelmed:________ Stress:__________ Irritable/Frustrated:_____

Other emotions/notes: