YOUR NAME: _____ DAY: _____

COACH: _____ DATE: _____

SLEEP

FILL IN THE NUMBER OF HOURS YOU GOT: _____

You should be getting an average of 7-8 hours of sleep per night

HEALTHY EATING TIP:

Make changes gradually.

WHAT I ATE TODAY

BREAKFAST	SNACK	LUNCH	SNACK	DINNER	SNACK (OPTIONAL)
TIME: ___:___ AM PM	TIME: ___:___ AM PM	TIME: ___:___ AM PM	TIME: ___:___ AM PM	TIME: ___:___ AM PM	TIME: ___:___ AM PM

DAILY SERVINGS CHECKLIST:

CHECK ALL THAT APPLY

PLEASE REFER TO YOUR TLS MENU PLAN FOR PROGRAM SPECIFIC POWER FOODS AND SERVING SIZES.

VEGETABLES	PROTEINS	FRUITS	DAIRY	GOOD FAT	LOW-GI STARCHES	WHOLE GRAINS
○○○○	○○○	○○	○○	○○	○○	○○
○○○○	○○○					
○○○○						

HYDRATION:

CHECK A GLASS FOR EACH 8 OZ. GLASS YOU DRANK TODAY

8 OZ. 8 OZ. 8 OZ. 8 OZ. 8 OZ. 8 OZ. 8 OZ. 8 OZ.

64 OZ.

SUPPLEMENTS:

CIRCLE THE SUPPLEMENTS YOU TOOK TODAY (READ THE LABEL FOR DIRECTIONS).

Multivitamin Thermochrome | CORE ACTS | CLA Green Coffee | Nutrition Shakes | Whey Protein Shakes

EXERCISE:

CHECK EACH EXERCISE YOU PERFORMED TODAY

CARDIO: # OF MINUTES	YOGA/STRETCH: # OF MINUTES	WEIGHT TRAINING: # OF MINUTES	OTHER: # OF MINUTES
_____	_____	_____	_____

WEEKS 3-13

Print 7 sheets for each week.
Use with your recommended meal plan, and include all suggested supplements.