THE MICRONUTRIENT MIRACLE

The 28-DAY PLAN to Lose Weight, Increase Your Energy, and Reverse Disease

WORKBOOK/JOURNAL

Mira Calton, CN & Jayson Calton, PhD

Daily Journal - Day 1

Date: _____ Day of the Week: _____

Meal 1: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 2: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 3: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 4: Time: _____(AM/PM) _____

_____ Supplements: _____

How much water? _____ Other beverages: _____

Time Lights Out? _____(AM/PM) Time Asleep? _____(AM/PM)

Time Woke Up? _____(AM/PM) Slept Through the Night? Yes / No

Energy level when you woke up (1-10): _____

How many bowel movements did you have? 0-3 or more? # of bowel movements: _____

Stress Level (1-10): _____ Symptoms (with severity 1-10): _____

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CALTON NUTRITION
DISCOVER HEALTH

Daily Journal - Day 2

Date: _____ Day of the Week: _____

Meal 1: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 2: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 3: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 4: Time: _____(AM/PM) _____

_____ Supplements: _____

How much water? _____ Other beverages: _____

Time Lights Out? _____(AM/PM) Time Asleep? _____(AM/PM)

Time Woke Up? _____(AM/PM) Slept Through the Night? Yes / No

Energy level when you woke up (1-10): _____

How many bowel movements did you have? 0-3 or more? # of bowel movements: _____

Stress Level (1-10): _____ Symptoms (with severity 1-10): _____

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CALTON NUTRITION
DISCOVER HEALTH

Daily Journal - Day 3

Date: _____ Day of the Week: _____

Meal 1: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 2: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 3: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 4: Time: _____(AM/PM) _____

_____ Supplements: _____

How much water? _____ Other beverages: _____

Time Lights Out? _____(AM/PM) Time Asleep? _____(AM/PM)

Time Woke Up? _____(AM/PM) Slept Through the Night? Yes / No

Energy level when you woke up (1-10): _____

How many bowel movements did you have? 0-3 or more? # of bowel movements: _____

Stress Level (1-10): _____ Symptoms (with severity 1-10): _____

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CALTON NUTRITION
DISCOVER HEALTH

Daily Journal - Day 4

Date: _____ Day of the Week: _____

Meal 1: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 2: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 3: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 4: Time: _____(AM/PM) _____

_____ Supplements: _____

How much water? _____ Other beverages: _____

Time Lights Out? _____(AM/PM) Time Asleep? _____(AM/PM)

Time Woke Up? _____(AM/PM) Slept Through the Night? Yes / No

Energy level when you woke up (1-10): _____

How many bowel movements did you have? 0-3 or more? # of bowel movements: _____

Stress Level (1-10): _____ Symptoms (with severity 1-10): _____

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CALTON NUTRITION
DISCOVER HEALTH

Daily Journal - Day 5

Date: _____ Day of the Week: _____

Meal 1: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 2: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 3: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 4: Time: _____(AM/PM) _____

_____ Supplements: _____

How much water? _____ Other beverages: _____

Time Lights Out? _____(AM/PM) Time Asleep? _____(AM/PM)

Time Woke Up? _____(AM/PM) Slept Through the Night? Yes / No

Energy level when you woke up (1-10): _____

How many bowel movements did you have? 0-3 or more? # of bowel movements: _____

Stress Level (1-10): _____ Symptoms (with severity 1-10): _____

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CALTON NUTRITION
DISCOVER HEALTH

Daily Journal - Day 6

Date: _____ Day of the Week: _____

Meal 1: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 2: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 3: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 4: Time: _____(AM/PM) _____

_____ Supplements: _____

How much water? _____ Other beverages: _____

Time Lights Out? _____(AM/PM) Time Asleep? _____(AM/PM)

Time Woke Up? _____(AM/PM) Slept Through the Night? Yes / No

Energy level when you woke up (1-10): _____

How many bowel movements did you have? 0-3 or more? # of bowel movements: _____

Stress Level (1-10): _____ Symptoms (with severity 1-10): _____

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CALTON NUTRITION
DISCOVER HEALTH

Daily Journal - Day 7

Date: _____ Day of the Week: _____

Meal 1: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 2: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 3: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 4: Time: _____(AM/PM) _____

_____ Supplements: _____

How much water? _____ Other beverages: _____

Time Lights Out? _____(AM/PM) Time Asleep? _____(AM/PM)

Time Woke Up? _____(AM/PM) Slept Through the Night? Yes / No

Energy level when you woke up (1-10): _____

How many bowel movements did you have? 0-3 or more? # of bowel movements: _____

Stress Level (1-10): _____ Symptoms (with severity 1-10): _____

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CALTON NUTRITION
DISCOVER HEALTH

Week 1 Checklist

CURRENT MEASUREMENTS

WEIGHT: _____(lbs)

NECK: _____(in)

CHEST: _____(in)

WAIST:_____(in)

HIPS:_____(in)

UPPER ARM/ BICEP:_____(in)

MID THIGH:_____(in)

CALF: _____(in)

BODY FAT: _____(%)**

LEAN MUSCLE: _____(lbs)**

Did you do your movement/exercise? (What type?)

DAY 1: _____

DAY 2: _____

DAY 3: _____

DAY 4: _____

DAY 5: _____

DAY 6: _____

DAY 7: _____

Average Sleep Time: _____

Average # Bowel Movements: _____

Average Energy Level (1-10): _____

Average Stress Level (1-10): _____

Most Common Symptoms: _____

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CALTON NUTRITION
DISCOVER HEALTH

Daily Journal - Day 8

Date: _____ Day of the Week: _____

Meal 1: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 2: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 3: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 4: Time: _____(AM/PM) _____

_____ Supplements: _____

How much water? _____ Other beverages: _____

Time Lights Out? _____(AM/PM) Time Asleep? _____(AM/PM)

Time Woke Up? _____(AM/PM) Slept Through the Night? Yes / No

Energy level when you woke up (1-10): _____

How many bowel movements did you have? 0-3 or more? # of bowel movements: _____

Stress Level (1-10): _____ Symptoms (with severity 1-10): _____

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CALTON NUTRITION
DISCOVER HEALTH

Daily Journal - Day 9

Date: _____ Day of the Week: _____

Meal 1: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 2: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 3: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 4: Time: _____(AM/PM) _____

_____ Supplements: _____

How much water? _____ Other beverages: _____

Time Lights Out? _____(AM/PM) Time Asleep? _____(AM/PM)

Time Woke Up? _____(AM/PM) Slept Through the Night? Yes / No

Energy level when you woke up (1-10): _____

How many bowel movements did you have? 0-3 or more? # of bowel movements: _____

Stress Level (1-10): _____ Symptoms (with severity 1-10): _____

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CALTON NUTRITION
DISCOVER HEALTH

Daily Journal - Day 10

Date: _____ Day of the Week: _____

Meal 1: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 2: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 3: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 4: Time: _____(AM/PM) _____

_____ Supplements: _____

How much water? _____ Other beverages: _____

Time Lights Out? _____(AM/PM) Time Asleep? _____(AM/PM)

Time Woke Up? _____(AM/PM) Slept Through the Night? Yes / No

Energy level when you woke up (1-10): _____

How many bowel movements did you have? 0-3 or more? # of bowel movements: _____

Stress Level (1-10): _____ Symptoms (with severity 1-10): _____

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CALTON NUTRITION
DISCOVER HEALTH

Daily Journal - Day 11

Date: _____ Day of the Week: _____

Meal 1: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 2: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 3: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 4: Time: _____(AM/PM) _____

_____ Supplements: _____

How much water? _____ Other beverages: _____

Time Lights Out? _____(AM/PM) Time Asleep? _____(AM/PM)

Time Woke Up? _____(AM/PM) Slept Through the Night? Yes / No

Energy level when you woke up (1-10): _____

How many bowel movements did you have? 0-3 or more? # of bowel movements: _____

Stress Level (1-10): _____ Symptoms (with severity 1-10): _____

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CALTON NUTRITION
DISCOVER HEALTH

Daily Journal - Day 12

Date: _____ Day of the Week: _____

Meal 1: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 2: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 3: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 4: Time: _____(AM/PM) _____

_____ Supplements: _____

How much water? _____ Other beverages: _____

Time Lights Out? _____(AM/PM) Time Asleep? _____(AM/PM)

Time Woke Up? _____(AM/PM) Slept Through the Night? Yes / No

Energy level when you woke up (1-10): _____

How many bowel movements did you have? 0-3 or more? # of bowel movements: _____

Stress Level (1-10): _____ Symptoms (with severity 1-10): _____

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CALTON NUTRITION
DISCOVER HEALTH

Daily Journal - Day 13

Date: _____ Day of the Week: _____

Meal 1: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 2: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 3: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 4: Time: _____(AM/PM) _____

_____ Supplements: _____

How much water? _____ Other beverages: _____

Time Lights Out? _____(AM/PM) Time Asleep? _____(AM/PM)

Time Woke Up? _____(AM/PM) Slept Through the Night? Yes / No

Energy level when you woke up (1-10): _____

How many bowel movements did you have? 0-3 or more? # of bowel movements: _____

Stress Level (1-10): _____ Symptoms (with severity 1-10): _____

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CALTON NUTRITION
DISCOVER HEALTH

Daily Journal - Day 14

Date: _____ Day of the Week: _____

Meal 1: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 2: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 3: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 4: Time: _____(AM/PM) _____

_____ Supplements: _____

How much water? _____ Other beverages: _____

Time Lights Out? _____(AM/PM) Time Asleep? _____(AM/PM)

Time Woke Up? _____(AM/PM) Slept Through the Night? Yes / No

Energy level when you woke up (1-10): _____

How many bowel movements did you have? 0-3 or more? # of bowel movements: _____

Stress Level (1-10): _____ Symptoms (with severity 1-10): _____

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CALTON NUTRITION
DISCOVER HEALTH

Week 2 Checklist

CURRENT MEASUREMENTS

WEIGHT: _____(lbs)

NECK: _____(in)

CHEST: _____(in)

WAIST:_____(in)

HIPS:_____(in)

UPPER ARM/ BICEP:_____(in)

MID THIGH:_____(in)

CALF: _____(in)

BODY FAT: _____(%)**

LEAN MUSCLE: _____(lbs)**

Did you do your movement/exercise? (What type?)

DAY 1: _____

DAY 2: _____

DAY 3: _____

DAY 4: _____

DAY 5: _____

DAY 6: _____

DAY 7: _____

Average Sleep Time: _____

Average # Bowel Movements: _____

Average Energy Level (1-10): _____

Average Stress Level (1-10): _____

Most Common Symptoms: _____

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CALTON NUTRITION
DISCOVER HEALTH

Daily Journal - Day 15

Date: _____ Day of the Week: _____

Meal 1: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 2: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 3: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 4: Time: _____(AM/PM) _____

_____ Supplements: _____

How much water? _____ Other beverages: _____

Time Lights Out? _____(AM/PM) Time Asleep? _____(AM/PM)

Time Woke Up? _____(AM/PM) Slept Through the Night? Yes / No

Energy level when you woke up (1-10): _____

How many bowel movements did you have? 0-3 or more? # of bowel movements: _____

Stress Level (1-10): _____ Symptoms (with severity 1-10): _____

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CALTON NUTRITION
DISCOVER HEALTH

Daily Journal - Day 16

Date: _____ Day of the Week: _____

Meal 1: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 2: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 3: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 4: Time: _____(AM/PM) _____

_____ Supplements: _____

How much water? _____ Other beverages: _____

Time Lights Out? _____(AM/PM) Time Asleep? _____(AM/PM)

Time Woke Up? _____(AM/PM) Slept Through the Night? Yes / No

Energy level when you woke up (1-10): _____

How many bowel movements did you have? 0-3 or more? # of bowel movements: _____

Stress Level (1-10): _____ Symptoms (with severity 1-10): _____

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CALTON NUTRITION
DISCOVER HEALTH

Daily Journal - Day 17

Date: _____ Day of the Week: _____

Meal 1: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 2: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 3: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 4: Time: _____(AM/PM) _____

_____ Supplements: _____

How much water? _____ Other beverages: _____

Time Lights Out? _____(AM/PM) Time Asleep? _____(AM/PM)

Time Woke Up? _____(AM/PM) Slept Through the Night? Yes / No

Energy level when you woke up (1-10): _____

How many bowel movements did you have? 0-3 or more? # of bowel movements: _____

Stress Level (1-10): _____ Symptoms (with severity 1-10): _____

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CALTON NUTRITION
DISCOVER HEALTH

Daily Journal - Day 18

Date: _____ Day of the Week: _____

Meal 1: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 2: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 3: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 4: Time: _____(AM/PM) _____

_____ Supplements: _____

How much water? _____ Other beverages: _____

Time Lights Out? _____(AM/PM) Time Asleep? _____(AM/PM)

Time Woke Up? _____(AM/PM) Slept Through the Night? Yes / No

Energy level when you woke up (1-10): _____

How many bowel movements did you have? 0-3 or more? # of bowel movements: _____

Stress Level (1-10): _____ Symptoms (with severity 1-10): _____

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CALTON NUTRITION
DISCOVER HEALTH

Daily Journal - Day 19

Date: _____ Day of the Week: _____

Meal 1: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 2: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 3: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 4: Time: _____(AM/PM) _____

_____ Supplements: _____

How much water? _____ Other beverages: _____

Time Lights Out? _____(AM/PM) Time Asleep? _____(AM/PM)

Time Woke Up? _____(AM/PM) Slept Through the Night? Yes / No

Energy level when you woke up (1-10): _____

How many bowel movements did you have? 0-3 or more? # of bowel movements: _____

Stress Level (1-10): _____ Symptoms (with severity 1-10): _____

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CALTON NUTRITION
DISCOVER HEALTH

Daily Journal - Day 20

Date: _____ Day of the Week: _____

Meal 1: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 2: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 3: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 4: Time: _____(AM/PM) _____

_____ Supplements: _____

How much water? _____ Other beverages: _____

Time Lights Out? _____(AM/PM) Time Asleep? _____(AM/PM)

Time Woke Up? _____(AM/PM) Slept Through the Night? Yes / No

Energy level when you woke up (1-10): _____

How many bowel movements did you have? 0-3 or more? # of bowel movements: _____

Stress Level (1-10): _____ Symptoms (with severity 1-10): _____

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CALTON NUTRITION
DISCOVER HEALTH

Daily Journal - Day 21

Date: _____ Day of the Week: _____

Meal 1: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 2: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 3: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 4: Time: _____(AM/PM) _____

_____ Supplements: _____

How much water? _____ Other beverages: _____

Time Lights Out? _____(AM/PM) Time Asleep? _____(AM/PM)

Time Woke Up? _____(AM/PM) Slept Through the Night? Yes / No

Energy level when you woke up (1-10): _____

How many bowel movements did you have? 0-3 or more? # of bowel movements: _____

Stress Level (1-10): _____ Symptoms (with severity 1-10): _____

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CALTON NUTRITION
DISCOVER HEALTH

Week 3 Checklist

CURRENT MEASUREMENTS

WEIGHT: _____(lbs)

NECK: _____(in)

CHEST: _____(in)

WAIST:_____(in)

HIPS:_____(in)

UPPER ARM/ BICEP:_____(in)

MID THIGH:_____(in)

CALF: _____(in)

BODY FAT: _____(%)**

LEAN MUSCLE: _____(lbs)**

Did you do your movement/exercise? (What type?)

DAY 1: _____

DAY 2: _____

DAY 3: _____

DAY 4: _____

DAY 5: _____

DAY 6: _____

DAY 7: _____

Average Sleep Time: _____

Average # Bowel Movements: _____

Average Energy Level (1-10): _____

Average Stress Level (1-10): _____

Most Common Symptoms: _____

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CALTON NUTRITION
DISCOVER HEALTH

Daily Journal - Day 22

Date: _____ Day of the Week: _____

Meal 1: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 2: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 3: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 4: Time: _____(AM/PM) _____

_____ Supplements: _____

How much water? _____ Other beverages: _____

Time Lights Out? _____(AM/PM) Time Asleep? _____(AM/PM)

Time Woke Up? _____(AM/PM) Slept Through the Night? Yes / No

Energy level when you woke up (1-10): _____

How many bowel movements did you have? 0-3 or more? # of bowel movements: _____

Stress Level (1-10): _____ Symptoms (with severity 1-10): _____

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CALTON NUTRITION
DISCOVER HEALTH

Daily Journal - Day 23

Date: _____ Day of the Week: _____

Meal 1: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 2: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 3: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 4: Time: _____(AM/PM) _____

_____ Supplements: _____

How much water? _____ Other beverages: _____

Time Lights Out? _____(AM/PM) Time Asleep? _____(AM/PM)

Time Woke Up? _____(AM/PM) Slept Through the Night? Yes / No

Energy level when you woke up (1-10): _____

How many bowel movements did you have? 0-3 or more? # of bowel movements: _____

Stress Level (1-10): _____ Symptoms (with severity 1-10): _____

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CALTON NUTRITION
DISCOVER HEALTH

Daily Journal - Day 24

Date: _____ Day of the Week: _____

Meal 1: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 2: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 3: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 4: Time: _____(AM/PM) _____

_____ Supplements: _____

How much water? _____ Other beverages: _____

Time Lights Out? _____(AM/PM) Time Asleep? _____(AM/PM)

Time Woke Up? _____(AM/PM) Slept Through the Night? Yes / No

Energy level when you woke up (1-10): _____

How many bowel movements did you have? 0-3 or more? # of bowel movements: _____

Stress Level (1-10): _____ Symptoms (with severity 1-10): _____

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CALTON NUTRITION
DISCOVER HEALTH

Daily Journal - Day 25

Date: _____ Day of the Week: _____

Meal 1: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 2: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 3: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 4: Time: _____(AM/PM) _____

_____ Supplements: _____

How much water? _____ Other beverages: _____

Time Lights Out? _____(AM/PM) Time Asleep? _____(AM/PM)

Time Woke Up? _____(AM/PM) Slept Through the Night? Yes / No

Energy level when you woke up (1-10): _____

How many bowel movements did you have? 0-3 or more? # of bowel movements: _____

Stress Level (1-10): _____ Symptoms (with severity 1-10): _____

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CALTON NUTRITION
DISCOVER HEALTH

Daily Journal - Day 26

Date: _____ Day of the Week: _____

Meal 1: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 2: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 3: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 4: Time: _____(AM/PM) _____

_____ Supplements: _____

How much water? _____ Other beverages: _____

Time Lights Out? _____(AM/PM) Time Asleep? _____(AM/PM)

Time Woke Up? _____(AM/PM) Slept Through the Night? Yes / No

Energy level when you woke up (1-10): _____

How many bowel movements did you have? 0-3 or more? # of bowel movements: _____

Stress Level (1-10): _____ Symptoms (with severity 1-10): _____

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CALTON NUTRITION
DISCOVER HEALTH

Daily Journal - Day 27

Date: _____ Day of the Week: _____

Meal 1: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 2: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 3: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 4: Time: _____(AM/PM) _____

_____ Supplements: _____

How much water? _____ Other beverages: _____

Time Lights Out? _____(AM/PM) Time Asleep? _____(AM/PM)

Time Woke Up? _____(AM/PM) Slept Through the Night? Yes / No

Energy level when you woke up (1-10): _____

How many bowel movements did you have? 0-3 or more? # of bowel movements: _____

Stress Level (1-10): _____ Symptoms (with severity 1-10): _____

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CALTON NUTRITION
DISCOVER HEALTH

Daily Journal - Day 28

Date: _____ Day of the Week: _____

Meal 1: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 2: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 3: Time: _____(AM/PM) _____

_____ Supplements: _____

Meal 4: Time: _____(AM/PM) _____

_____ Supplements: _____

How much water? _____ Other beverages: _____

Time Lights Out? _____(AM/PM) Time Asleep? _____(AM/PM)

Time Woke Up? _____(AM/PM) Slept Through the Night? Yes / No

Energy level when you woke up (1-10): _____

How many bowel movements did you have? 0-3 or more? # of bowel movements: _____

Stress Level (1-10): _____ Symptoms (with severity 1-10): _____

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CALTON NUTRITION
DISCOVER HEALTH

Week 4 Checklist

CURRENT MEASUREMENTS

WEIGHT: _____(lbs)

NECK: _____(in)

CHEST: _____(in)

WAIST:_____(in)

HIPS:_____(in)

UPPER ARM/ BICEP:_____(in)

MID THIGH:_____(in)

CALF: _____(in)

BODY FAT: _____(%)**

LEAN MUSCLE: _____(lbs)**

Did you do your movement/exercise? (What type?)

DAY 1: _____

DAY 2: _____

DAY 3: _____

DAY 4: _____

DAY 5: _____

DAY 6: _____

DAY 7: _____

Average Sleep Time: _____

Average # Bowel Movements: _____

Average Energy Level (1-10): _____

Average Stress Level (1-10): _____

Most Common Symptoms: _____

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CALTON NUTRITION
DISCOVER HEALTH