

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

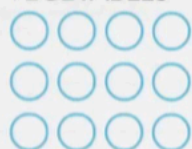
TIME: ____:____ AM
PM

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

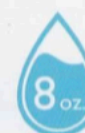


WHOLE
GRAINS



HYDRATION:

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



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.

