NAME: _____

DAY: ☐ M ☐ T ☐ W ☐ TH ☐ F ☐ SAT ☐ SUN

DATE:

ITEM TIME(S)	AMOUNT	EMOTIONAL/PHYSICAL CHECK-IN
BREAKFAST:		
LUNCH:		
DINNER:		
SNACKS:		
WATER:	8 OZ	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐