

Name: \_\_\_\_\_

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Breakfast							
Lunch							
Dinner							
Treat							
Water							
Fruit							

**Yes**   **No**   Now, how do you feel about yourself?

Have you eaten everything under 5% fat?

<input type="checkbox"/>	<input type="checkbox"/>
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\_\_\_\_\_

Have you eaten 3 pieces of fruit and plenty of Vegetable/salad each day?

<input type="checkbox"/>	<input type="checkbox"/>
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Have you had 5 glasses of water a day?

<input type="checkbox"/>	<input type="checkbox"/>
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\_\_\_\_\_

Have you exercised this week, 3 times for at least 20 minutes?

<input type="checkbox"/>	<input type="checkbox"/>
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Have you consumed any alcohol?

<input type="checkbox"/>	<input type="checkbox"/>
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WEIGHT LOST THIS WEEK: lbs

**Janie  
cremer**