1. Brien Shamp Nutrition Record Sheet



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This nutrition record sheet is designed for you to assess how you feel after each meal. The record sheet for each meal should be completed 1-2 hours after each meal and the final questionnaire at the end of the day. Select the answer that bests describes how you are feeling in each multiple choice question. All questions should be answered.

Proteins: 1 Serving = A Deck of Cards = 3 OZ Carbs (Veggies/Bread): 1 Serving = 1 Fist

Fats: 1 Serving = 1 TBSP

You will need this blank questionnaire to use daily. When you first open this PDF file, click on File > Save As > then type in a new name, ideally the date (i.e. 12-03-2014) and then choose "Save". This will create a copy of this document on your computer and preserve the blank for future days.

When you have completed the questionnaire, please email it to Brien at beshamp@brienshamp.com, then save your copy on your computer in the folder of your choice for future reference.

1. Your full name:	
2. Today's date:	

C. Yes C. No S. Enter the time you ate breakfast: S. List all the foods that you ate for breakfast including beverages and condiments (sugaralt, spices). S. Hunger Level: Not at all Maybe a little I could eat more I'm hungry now I'm starving! Colors: S. Cravings level: No sweet cravings A little craving for something sweet Definitely want something sweet Cravings Level: C. Cravings Level: Energy feels Good, lasting Too much energy (jittery, hyper, etc.) Not enough energy but exhausted underneath (tired, listles: lethargic) Energy level: C. C	. Did you eat br	eakfast?				
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○ No					
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7. Final Questionnaire
1. How much water did you drink today? Please specify whether the amount is in cups or ounces.
2. What was the source of the water you drank? (i.e. bottled spring water, reverse osmosis,
tap, etc.)
3. Did you consume additional beverages?
C Yes
O No
*4. If YES, what else did you drink & how much? Please specify if it is in cups or ounces.
5. Did you experience any digestive problems after any meals (I.e. bloating, gas, GERD)?
C No
6. What time did you go to bed last night?
7. What time did you get up this morning?
8. How did you sleep last night?
C Soundly
C Restless
9. Did you awake during the night?
C Yes
O No
10. If you did wake up during the night, describe the reason:
11. Did you have night sweats?
C Yes
○ No

12. Did you wake up refreshed or tired?
C Refreshed
C Tired
13. Are you a slow starter in the morning?
C Yes
O No
14. If YES, how long does it take to feel alert each morning?
<u>^</u>
15. How did you feel overall today from this diet? Did you do well or poorly on it?
16. Did you get any exercise?
C Yes
O No
17. If YES, describe the time you exercised, the type and duration:
18. Did you get any relaxation?
C Yes
O No
19. NO If YES, describe the type and duration:
<u>^</u>
20. Did you journal your challenges, gratitude and positive experiences?
C Yes
O No