HEALTHY LIVING

Planner

MONTH At Glance

MONTH

SUN	MON	TUE	WED	THU	FRI	SAT

Notes:

Monday

Date:

Weather: 

Schedule
6 am
7 am
8 am
9 am
10 am
11 am
12 pm
1 pm
2 pm
3 pm
4 pm
5 pm
6 pm
7 pm
8 pm
9 pm
10 pm
11 pm

To- Do List

- ◯
- ◯
- ◯
- ◯
- ◯

Daily Priorities

- ◯
- ◯
- ◯

Water Balance

Mood

Tuesday

Date:

Weather: 

Schedule
6 am
7 am
8 am
9 am
10 am
11 am
12 pm
1 pm
2 pm
3 pm
4 pm
5 pm
6 pm
7 pm
8 pm
9 pm
10 pm
11 pm

To- Do List

- ◯
- ◯
- ◯
- ◯
- ◯

Daily Priorities

- ◯
- ◯
- ◯

Water Balance

Mood

Wednesday

Date:

Weather: 

Schedule
6 am
7 am
8 am
9 am
10 am
11 am
12 pm
1 pm
2 pm
3 pm
4 pm
5 pm
6 pm
7 pm
8 pm
9 pm
10 pm
11 pm

To- Do List

- ◯
- ◯
- ◯
- ◯
- ◯

Daily Priorities

- ◯
- ◯
- ◯

Water Balance

Mood

Thursday

Date:

Weather: 

Schedule
6 am
7 am
8 am
9 am
10 am
11 am
12 pm
1 pm
2 pm
3 pm
4 pm
5 pm
6 pm
7 pm
8 pm
9 pm
10 pm
11 pm

To- Do List

- ◯
- ◯
- ◯
- ◯
- ◯

Daily Priorities

- ◯
- ◯
- ◯

Water Balance

Mood

Friday

Date:

Weather: 

Schedule
6 am
7 am
8 am
9 am
10 am
11 am
12 pm
1 pm
2 pm
3 pm
4 pm
5 pm
6 pm
7 pm
8 pm
9 pm
10 pm
11 pm

To- Do List

- ◯
- ◯
- ◯
- ◯
- ◯

Daily Priorities

- ◯
- ◯
- ◯

Water Balance

Mood

Saturday

Date:

Weather: 

Schedule
6 am
7 am
8 am
9 am
10 am
11 am
12 pm
1 pm
2 pm
3 pm
4 pm
5 pm
6 pm
7 pm
8 pm
9 pm
10 pm
11 pm

To- Do List

- ◯
- ◯
- ◯
- ◯
- ◯

Daily Priorities

- ◯
- ◯
- ◯

Water Balance

Mood

Sunday

Date:

Weather: 

Schedule
6 am
7 am
8 am
9 am
10 am
11 am
12 pm
1 pm
2 pm
3 pm
4 pm
5 pm
6 pm
7 pm
8 pm
9 pm
10 pm
11 pm

To- Do List

- ◯
- ◯
- ◯
- ◯
- ◯

Daily Priorities

- ◯
- ◯
- ◯

Water Balance

Mood

MOTIVATIONS & Inspirations

GRATITUDE Journal

Week:_____

I AM GRATEFUL FOR...

MONDAY _____

_____

_____

TUESDAY _____

_____

_____

WEDNESDAY _____

_____

_____

THURSDAY _____

_____

_____

FRIDAY _____

_____

_____

SATURDAY _____

_____

_____

SUNDAY _____

_____

_____

SPENDING Log

DATE	ITEM	AMOUNT	NEED?	WANT?

BUCKET List

TO-DO List

- [ ]
- [ ]
- [ ]
- [ ]
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- [ ]

Notes

DATE:

VISION Board

POSITIVE Affirmations

MY POSITIVE AFFIRMATION STATEMENT

- [ ] _____
- [ ] _____
- [ ] _____
- [ ] _____
- [ ] _____
- [ ] _____
- [ ] _____
- [ ] _____
- [ ] _____
- [ ] _____
- [ ] _____
- [ ] _____
- [ ] _____
- [ ] _____
- [ ] _____
- [ ] _____

HABIT Tracker

MONTH:

THIS MONTH'S GOALS

1.	2.	3.

HABIT	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	31
	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	

HABIT	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	31
	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	

HABIT	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	31
	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	

HABIT	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	31
	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	

HABIT	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	31
	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	

HABIT	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	31
	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	

HABIT	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	31
	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	

Notes

HABIT Tracker

WEEK:

HABIT	M	T	W	T	F	S	S

POSITIVE Mindset

NEGATIVE THOUGHT	POSITIVE THOUGHT
NEGATIVE THOUGHT	**POSITIVE THOUGHT**
NEGATIVE THOUGHT	**POSITIVE THOUGHT**
NEGATIVE THOUGHT	**POSITIVE THOUGHT**

APPOINTMENTS

PLACE: _____ **DATE:** _____

DOCTOR: _____

APPOINTMENT PURPOSE: _____

_____

QUESTIONS TO ASK

- [ ] _____
- [ ] _____
- [ ] _____

DOCTOR NOTES

_____

_____

_____

_____

_____

_____

_____

_____

AFTER APPOINTMENT TO-DO LIST

- [ ] _____
- [ ] _____
- [ ] _____
- [ ] _____
- [ ] _____
- [ ] _____

MEDICATION Tracker

MEDICATION	DOSE	FREQUENCY	CONDITION	PHYSICIAN
NOTES				
NOTES				
NOTES				
NOTES				
NOTES				
NOTES				
NOTES				
NOTES				
NOTES				
NOTES				
NOTES				
NOTES				

EMERGENCY Contacts

NAME _____

ADDRESS _____

STATE/ZIP _____ CITY _____

WORK PH # _____ HOME PH # _____

RELATIONSHIP _____ CELL PH# _____

NAME _____

ADDRESS _____

STATE/ZIP _____ CITY _____

WORK PH # _____ HOME PH # _____

RELATIONSHIP _____ CELL PH# _____

NAME _____

ADDRESS _____

STATE/ZIP _____ CITY _____

WORK PH # _____ HOME PH # _____

RELATIONSHIP _____ CELL PH# _____

NAME _____

ADDRESS _____

STATE/ZIP _____ CITY _____

WORK PH # _____ HOME PH # _____

RELATIONSHIP _____ CELL PH# _____

HEALTHCARE PROVIDER Visits

VISIT DETAILS

DATE _____ APPT . TIME _____

PROVIDER _____ SPECIALITY _____

REASON FOR VISIT _____

CONCERNS

_____

VITALS

HEIGHT _____ WEIGHT _____

BLOOD PRESSURE _____ PULSE RATE _____

BLOOD GLUCOSE _____ TEMPERATURE _____

PROVIDER DIAGNOSIS

_____

TEST ORDERED

TEST _____ FACILITY _____

DATE _____ APPT. TIME _____

REASON FOR VISIT _____

TEST RESULTS _____

MEDICATION UPDATES

MEDICATION _____ MEDICATION _____

CONDITION _____ CONDITION _____

DOSE/FREQUENCY _____ DOSE/FREQUENCY _____

START DATE/END DATE _____ START DATE/END DATE _____

NOTE _____ NOTE _____

MY MEDICAL Quick View

NAME _____ **DONOR** _____

DATE OF BIRTH _____ **BLOOD TYPE** _____

HEIGHT _____ **WEIGHT** _____

MEDICAL CONDITIONS

CONDITION	MEDICATION

ALLERGIES

ALLERGY _____ **MEDS** _____

REACTION _____

ALLERGY _____ **MEDS** _____

REACTION _____

ALLERGY _____ **MEDS** _____

REACTION _____

URGENT CARE Visits

FACILITY/DR .... DATE ....

REASON .... TEMPERATURE ....

BLOOD PRESSURE ....

TESTS ....

RESULTS ....

PRESCRIPTIONS ....

DISCHARGE INSTRUCTIONS ....

FACILITY/DR .... DATE ....

REASON .... TEMPERATURE ....

BLOOD PRESSURE ....

TESTS ....

RESULTS ....

PRESCRIPTIONS ....

DISCHARGE INSTRUCTIONS ....

FACILITY/DR .... DATE ....

REASON .... TEMPERATURE ....

BLOOD PRESSURE ....

TESTS ....

RESULTS ....

PRESCRIPTIONS ....

DISCHARGE INSTRUCTIONS ....

EYE CARE Tracker

NAME _____

DOCTOR _____

APPT. DATE _____ **APPT. TIME** _____

RIGHT EYE _____

LEFT EYE _____

COST _____ **AMOUNT PAID** _____

NOTES

_____

_____

_____

_____

_____

NAME _____

DOCTOR _____

APPT. DATE _____ **APPT. TIME** _____

RIGHT EYE _____

LEFT EYE _____

COST _____ **AMOUNT PAID** _____

NOTES

_____

_____

_____

_____

_____

NAME _____

DOCTOR _____

APPT. DATE _____ **APPT. TIME** _____

RIGHT EYE _____

LEFT EYE _____

COST _____ **AMOUNT PAID** _____

NOTES

_____

_____

_____

_____

_____

DENTAL Visits

NAME ______________________ APPT. DATE ______________ APPT. TIME ________

DENTIST ______________________ REASON ______________________

CLEANING: ☐ Yes ☐ No Comments: ______________________

X-RAYS: ☐ Yes ☐ No Comments: ______________________

PROCEDURES ______________________

DISCUSSION NOTES ______________________

____

FOLLOW UP NEEDED: ☐ Yes ☐ No APPT. DATE ______________ APPT. TIME ________

COST ________ INSURANCE ________ OUT OF POCKET ________ AMOUNT PAID ________

NAME ______________________ APPT. DATE ______________ APPT. TIME ________

DENTIST ______________________ REASON ______________________

CLEANING: ☐ Yes ☐ No Comments: ______________________

X-RAYS: ☐ Yes ☐ No Comments: ______________________

PROCEDURES ______________________

DISCUSSION NOTES ______________________

____

FOLLOW UP NEEDED: ☐ Yes ☐ No APPT. DATE ______________ APPT. TIME ________

COST ________ INSURANCE ________ OUT OF POCKET ________ AMOUNT PAID ________

NAME ______________________ APPT. DATE ______________ APPT. TIME ________

DENTIST ______________________ REASON ______________________

CLEANING: ☐ Yes ☐ No Comments: ______________________

X-RAYS: ☐ Yes ☐ No Comments: ______________________

PROCEDURES ______________________

DISCUSSION NOTES ______________________

____

FOLLOW UP NEEDED: ☐ Yes ☐ No APPT. DATE ______________ APPT. TIME ________

COST ________ INSURANCE ________ OUT OF POCKET ________ AMOUNT PAID ________

GROCERY List

MEAL Planner

WEEK _____

	BREAKFAST	LUNCH	DINNER
Monday			
Tuesday			
Wednesday			
Thursday			
Friday			
Saturday			
Sunday			

MEAL Planner

M T W T F S S

BREAKFAST

Menu

CALORIES	PROTEIN	CARBS	FAT

Time: _____

LUNCH

Menu

CALORIES	PROTEIN	CARBS	FAT

Time: _____

SNACK

Menu

CALORIES	PROTEIN	CARBS	FAT

Time: _____

DINNER

Menu

CALORIES	PROTEIN	CARBS	FAT

Time: _____

CALORIE Tracker

DAY:

BREAKFAST	PROTEINS	CALORIES	CARBS	FATS

LUNCH	PROTEINS	CALORIES	CARBS	FATS

DINNER	PROTEINS	CALORIES	CARBS	FATS

SNACKS	PROTEINS	CALORIES	CARBS	FATS

SYMPTOMS Tracker

Date::

BREAKFAST	SYMPTOMS
SYMPTOMS SEVERITY 1 2 3 4 5 6 7 8 9 10	

LUNCH	SYMPTOMS
SYMPTOMS SEVERITY 1 2 3 4 5 6 7 8 9 10	

DINNER	SYMPTOMS
SYMPTOMS SEVERITY 1 2 3 4 5 6 7 8 9 10	

SNACK	SYMPTOMS
SYMPTOMS SEVERITY 1 2 3 4 5 6 7 8 9 10	

MY MOOD TODAY

WATER INTAKE:

FOOD Results

GOOD FOODS	BAD FOODS

NOT SURE FOODS

HEALTHY Recipe

RECIPE NAME _____

INGREDIENTS

- ☐
- ☐
- ☐
- ☐
- ☐
- ☐
- ☐
- ☐
- ☐
- ☐
- ☐
- ☐
- ☐
- ☐
- ☐
- ☐
- ☐
- ☐

DESCRIPTION

PREP TIME

COOK TIME

CALORIES

TEMPERATURE

DIFFICULTY

RATING

★ ★ ★ ★ ★

NOTES

FAVORITE KETO Food

KETO FRIENFDLY FOOD	NET CARBS	PROTEIN	FAT

SLEEP Tracker

Month:

	HOURS OF SLEEP										
Day	01	02	03	04	05	06	07	08	09	10	DREAMS
01											
02											
03											
04											
05											
06											
07											
08											
09											
10											
11											
12											
13											
14											
15											
16											
17											
18											
19											
20											
21											
22											
23											
24											
25											
26											
27											
28											
29											
30											
31											

PERIOD LoG

Month:

MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY

INGREDIENTS	
CYCLE START	
DAYS IN CYCLE	
MENSTRUATION FLOW	
NEXT CYCLE START DATE	
SYMPTOMS	

COLOR KEY	

SYMPTOMS Tracker

WEEK _____

SYMPTOM	MON	TUE	WED	THU	FRI	SAT	SUN

NOTE

WEIGHT LOSS Tracker

January

WEEK 1
WEEK 2
WEEK 3
WEEK 4
DIFFERENCE

February

WEEK 1
WEEK 2
WEEK 3
WEEK 4
DIFFERENCE

March

WEEK 1
WEEK 2
WEEK 3
WEEK 4
DIFFERENCE

April

WEEK 1
WEEK 2
WEEK 3
WEEK 4
DIFFERENCE

May

WEEK 1
WEEK 2
WEEK 3
WEEK 4
DIFFERENCE

June

WEEK 1
WEEK 2
WEEK 3
WEEK 4
DIFFERENCE

WEIGHT LOSS Tracker

July

WEEK 1
WEEK 2
WEEK 3
WEEK 4
DIFFERENCE

August

WEEK 1
WEEK 2
WEEK 3
WEEK 4
DIFFERENCE

September

WEEK 1
WEEK 2
WEEK 3
WEEK 4
DIFFERENCE

October

WEEK 1
WEEK 2
WEEK 3
WEEK 4
DIFFERENCE

November

WEEK 1
WEEK 2
WEEK 3
WEEK 4
DIFFERENCE

December

WEEK 1
WEEK 2
WEEK 3
WEEK 4
DIFFERENCE

WORKOUT Plan

MUSCLES GROUP ..... **DAY** .....

EXERCICE	WEIGHT	REPS	SETS	TIME

SKIN Care

BEAUTY ROUTINE	PRODUCT	M	T	W	T	F	S	S

SELF-CARE Goal Plan

MAIN GOAL:		
◯ MENTAL & SPIRITUAL	◯ PHYSICAL	◯ SOCIAL
START DATE:	END DATE:	DURATION:

OBJECTIVES

- ◯ _____
- ◯ _____
- ◯ _____
- ◯ _____
- ◯ _____

ACTION STEPS	DUE

RESULTS

_____

_____

_____

_____

DAILY Self-Care

DATE:	MON	TUE	WED	THU	FRI	SAT	SUN

TODAY'S GOAL:

TO-DO LIST	
◯	
◯	
◯	
◯	
◯	

WHAT AM I GRATEFUL FOR TODAY:

MEALS

B	L	D
KCAL	KCAL	KCAL

WATER INTAKE: 

TODAY'S EXERCISE

◯	
◯	
◯	

EXERCISE Activity

DATE	ACTIVITY	TIME	DISTACNCE	SETS	REPS	INTENSITY	CALORIES BURNED	ETC

DAILY WELLNESS Journal

DAY .....

	WHAT I ATE TODAY
B	
L	
D	
S	

HOW I SLEPT LAST NIGHT

WATER INTAKE: 

SYMPTOM TRACKER

- ◯
- ◯
- ◯
- ◯
- ◯
- ◯
- ◯
- ◯

NOTES

ACTIVITIES

DAILY CHECK-UP

MY PAIN LEVEL

1	2	3	4	5	6	7	8	9	10

MY LEVEL OF FATIGUE

1	2	3	4	5	6	7	8	9	10

MY DEGREE OF BRAIN FOG

1	2	3	4	5	6	7	8	9	10

MY LEVEL OF ANXIETY

1	2	3	4	5	6	7	8	9	10

MY OVERALL MOOD TODAY

1	2	3	4	5	6	7	8	9	10

WHY I FEEL THIS WAY TODAY

NOTES