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PERFORMANCE TRAINING



LIFESTYLE DIARY

Lifestyle choices are the most underestimated factor in any health, fitness or wellness program. A lifestyle diary helps bring accountability and awareness to daily habits and go-to strategies, and allows us to identify and address any potential limiting factors outside of your training, that may hinder your ability to get the results you want.

Please take the time to complete the following survey carefully and accurately.

List in detail the quantity and the exact nature of all foods and beverages consumed (i.e. frozen, canned, organic, etc.). Please note if the foods were raw or cooked. Be sure to list all beverages, all fats or oils and any condiments used (i.e. mayonnaise, mustard, relish, salad dressing, etc.). Please list any supplements or medications that you are taking.

In regards to the exercise portion, please list the type and duration of exercise (ie weights, cardio, yoga, spin class). Also record any relaxation periods or recovery practices ie meditation, walking, massage, Epsom salts bath, foam rolling, acupuncture, sauna.

Please take your resting heart rate each morning as soon as you wake up for at least 3 consecutive days. This can be a good measure of stress.

Start taking note of your energy cycles and moods throughout the day, especially after your meals. As uncomfortable as it may be, it is also useful to take note of your bowel movements as they give a good indication of digestive health, and any PMS symptoms or irregularities in menstrual cycles.

Be as honest as possible. This is NOT an exercise in judgement – the more information I have, the more personalized your experience can be.

Day 1: Resting heart rate:

Date:

Meal 1: Time:	Water & source (ie plastic bottle, tap etc)
Snack 1: Time:	Additional Beverages
Meal 2: Time:	Condiments (sugar, salt, spices etc)
Snack 2: Time:	Fats/oils
Meal 3: Time:	Exercise type and duration
Snack 3: Time:	Relaxation type and duration

What time did you go to bed last night?

How long did it take you to fall asleep?

Why could you not fall asleep? Stressed Wired Not tired Sore/stiff Anxious

What time did you get up this morning?

How was your sleep quality? Sound Restless

Did you awake during the night - Reasons:

What time/s did you wake?

Did you have night sweats? YES NO

Did you have any dreams? YES/NO

Did you wake up refreshed? Or tired?

Are you a slow starter in the morning? YES NO

If Yes, how long does it take to feel alert each morning?

Did you sleep in a room with any light or noise?

Did you wake up only with an alarm?

Did you use medications for sleep for sleep?

How many bowel movements did you have today?

Any other notes: (can include stress/anxiety levels, PMS symptoms, injuries/illnesses and performance ratings):

Day 2: Resting heart rate:

Date:

Meal 1: Time:	Water & source (ie plastic bottle, tap etc)
Snack 1: Time:	Additional Beverages
Meal 2: Time:	Condiments (sugar, salt, spices etc)
Snack 2: Time:	Fats/oils
Meal 3: Time:	Exercise type and duration
Snack 3: Time:	Relaxation type and duration

What time did you go to bed last night?

How long did it take you to fall asleep?

Why could you not fall asleep? Stressed Wired Not tired Sore/stiff Anxious

What time did you get up this morning?

How was your sleep quality? Sound Restless

Did you awake during the night - Reasons:

What time/s did you wake?

Did you have night sweats? YES NO

Did you have any dreams? YES/NO

Did you wake up refreshed? Or tired?

Are you a slow starter in the morning? YES NO

If Yes, how long does it take to feel alert each morning?

Did you sleep in a room with any light or noise?

Did you wake up only with an alarm?

Did you use medications for sleep for sleep?

How many bowel movements did you have today?

Any other notes: (can include stress/anxiety levels, PMS symptoms, injuries/illnesses and performance ratings):

Day 3: Resting heart rate:

Date:

Meal 1: Time:	Water & source (ie plastic bottle, tap etc)
Snack 1: Time:	Additional Beverages
Meal 2: Time:	Condiments (sugar, salt, spices etc)
Snack 2: Time:	Fats/oils
Meal 3: Time:	Exercise type and duration
Snack 3: Time:	Relaxation type and duration

What time did you go to bed last night?

How long did it take you to fall asleep?

Why could you not fall asleep? Stressed Wired Not tired Sore/stiff Anxious

What time did you get up this morning?

How was your sleep quality? Sound Restless

Did you awake during the night - Reasons:

What time/s did you wake?

Did you have night sweats? YES NO

Did you have any dreams? YES/NO

Did you wake up refreshed? Or tired?

Are you a slow starter in the morning? YES NO

If Yes, how long does it take to feel alert each morning?

Did you sleep in a room with any light or noise?

Did you wake up only with an alarm?

Did you use medications for sleep for sleep?

How many bowel movements did you have today?

Any other notes: (can include stress/anxiety levels, PMS symptoms, injuries/illnesses and performance ratings):

Day 4: Resting heart rate:

Date:

Meal 1: Time:	Water & source (ie plastic bottle, tap etc)
Snack 1: Time:	Additional Beverages
Meal 2: Time:	Condiments (sugar, salt, spices etc)
Snack 2: Time:	Fats/oils
Meal 3: Time:	Exercise type and duration
Snack 3: Time:	Relaxation type and duration

What time did you go to bed last night?
How long did it take you to fall asleep?
Why could you not fall asleep? Stressed Wired Not tired Sore/stiff Anxious
What time did you get up this morning?
How was your sleep quality? Sound Restless
Did you awake during the night - Reasons:
What time/s did you wake?
Did you have night sweats? YES NO
Did you have any dreams? YES/NO
Did you wake up refreshed? Or tired?
Are you a slow starter in the morning? YES NO
If Yes, how long does it take to feel alert each morning?
Did you sleep in a room with any light or noise?
Did you wake up only with an alarm?
Did you use medications for sleep for sleep?

How many bowel movements did you have today?

Any other notes: (can include stress/anxiety levels, PMS symptoms, injuries/illnesses and performance ratings):

Day 5: Resting heart rate:

Date:

Meal 1: Time:	Water & source (ie plastic bottle, tap etc)
Snack 1: Time:	Additional Beverages
Meal 2: Time:	Condiments (sugar, salt, spices etc)
Snack 2: Time:	Fats/oils
Meal 3: Time:	Exercise type and duration
Snack 3: Time:	Relaxation type and duration

What time did you go to bed last night?
How long did it take you to fall asleep?
Why could you not fall asleep? Stressed Wired Not tired Sore/stiff Anxious
What time did you get up this morning?
How was your sleep quality? Sound Restless
Did you awake during the night - Reasons:
What time/s did you wake?
Did you have night sweats? YES NO
Did you have any dreams? YES/NO
Did you wake up refreshed? Or tired?
Are you a slow starter in the morning? YES NO
If Yes, how long does it take to feel alert each morning?
Did you sleep in a room with any light or noise?
Did you wake up only with an alarm?
Did you use medications for sleep for sleep?

How many bowel movements did you have today?

Any other notes: (can include stress/anxiety levels, PMS symptoms, injuries/illnesses and performance ratings):

Day 6: Resting heart rate:

Date:

Meal 1: Time:	Water & source (ie plastic bottle, tap etc)
Snack 1: Time:	Additional Beverages
Meal 2: Time:	Condiments (sugar, salt, spices etc)
Snack 2: Time:	Fats/oils
Meal 3: Time:	Exercise type and duration
Snack 3: Time:	Relaxation type and duration

What time did you go to bed last night?

How long did it take you to fall asleep?

Why could you not fall asleep? Stressed Wired Not tired Sore/stiff Anxious

What time did you get up this morning?

How was your sleep quality? Sound Restless

Did you awake during the night - Reasons:

What time/s did you wake?

Did you have night sweats? YES NO

Did you have any dreams? YES/NO

Did you wake up refreshed? Or tired?

Are you a slow starter in the morning? YES NO

If Yes, how long does it take to feel alert each morning?

Did you sleep in a room with any light or noise?

Did you wake up only with an alarm?

Did you use medications for sleep for sleep?

How many bowel movements did you have today?

Any other notes: (can include stress/anxiety levels, PMS symptoms, injuries/illnesses and performance ratings):

Day 7: Resting heart rate:

Date:

Meal 1: Time:	Water & source (ie plastic bottle, tap etc)
Snack 1: Time:	Additional Beverages
Meal 2: Time:	Condiments (sugar, salt, spices etc)
Snack 2: Time:	Fats/oils
Meal 3: Time:	Exercise type and duration
Snack 3: Time:	Relaxation type and duration

What time did you go to bed last night?
How long did it take you to fall asleep?
Why could you not fall asleep? Stressed Wired Not tired Sore/stiff Anxious
What time did you get up this morning?
How was your sleep quality? Sound Restless
Did you awake during the night - Reasons:
What time/s did you wake?
Did you have night sweats? YES NO
Did you have any dreams? YES/NO
Did you wake up refreshed? Or tired?
Are you a slow starter in the morning? YES NO
If Yes, how long does it take to feel alert each morning?
Did you sleep in a room with any light or noise?
Did you wake up only with an alarm?
Did you use medications for sleep for sleep?

How many bowel movements did you have today?

Any other notes: (can include stress/anxiety levels, PMS symptoms, injuries/illnesses and performance ratings):

Other questions

Have you ever had a food allergy test? If yes, please name any food sensitivities

Please list the major stressors in your life

Do you have children? YES/NO

Please list any other relevant medical history inclusive of surgeries (health/injury/cosmetic), test results ie thyroid, diabetes, high cholesterol, vitamin & mineral deficiencies, hormonal imbalances.

Please list any other injuries that affect both your training performance and your quality of life.

Please list your major goals in order from 1-3: