



*'the feels' check-in*

4-MONTH WELLNESS TRACKER  
WITHOUT USING THE SCALE!

Body, Mind, and Soul Transformation



# a note from the Coaches

“The number on the scale  
does NOT define who you are”

First we want to welcome and congratulate you for embracing this NEW way of seeing health and wellness. One where the number on the scale is just another number. Where it doesn't define you as a person or how healthy you are. Where it doesn't have power over you.

Instead of tracking weight, we invite you to complete a check-in once a month for the duration of the program. We call it 'the feels check-in'. This is how it works:

Once a month, fill out the pages for that correspond to that month. You'll rate each symptom whether you felt it rarely or often. This way you'll be able to compare and track your monthly progress. The REAL progress!

And as bonus, plan out the different ways you'll practice weekly self-care for the month. Now that's how to really love, honor, and take care of our bodies. Don't you think?

Love always,  
Raisa and Megan





# Month 1

Body, Mind, and Soul Transformation

# Month 1 check-in

RATE EACH SYMPTOM ACCORDING TO HOW YOU FELT THIS WEEK.  
USE THE FOLLOWING POINT SCALE:

0 = NEVER; 1 = SOMETIMES MILD; 2 = SOMETIMES SEVERE; 3 = FREQUENTLY MILD; 4 = FREQUENTLY SEVERE

## HEAD + MIND

- |  |   |
|--|---|
| <input type="checkbox"/> Headache                    | <input type="checkbox"/> Poor concentration |
| <input type="checkbox"/> Migraine                    | <input type="checkbox"/> Brain fog          |
| <input type="checkbox"/> Forgetfulness / poor memory | <input type="checkbox"/> Dizziness          |

## EYES + NOSE + SKIN

- |   |   |
|---|---|
| <input type="checkbox"/> Watery eyes            | <input type="checkbox"/> Sinus discomfort |
| <input type="checkbox"/> Blurred vision         | <input type="checkbox"/> Acne             |
| <input type="checkbox"/> Congested / runny nose | <input type="checkbox"/> Hives / rashes   |

## DIGESTIVE

- |                                    |                                       |
|------------------------------------|---------------------------------------|
| <input type="checkbox"/> Nausea    | <input type="checkbox"/> Diarrhea     |
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Bloat     | <input type="checkbox"/> Vomiting     |

# Month 1 check-in

RATE EACH SYMPTOM ACCORDING TO HOW YOU FELT THIS WEEK.  
USE THE FOLLOWING POINT SCALE:

0 = NEVER; 1 = SOMETIMES MILD; 2 = SOMETIMES SEVERE; 3 = FREQUENTLY MILD; 4 = FREQUENTLY SEVERE

## ENERGY + MOOD

Fatigue

Anger / irritability

Hyperactive

Depression

Mood swings

Anxiety

## SLEEP

Difficulty falling asleep

Restless legs

Difficulty staying asleep

Leg cramping

Insomnia

Daytime drowsiness

## OTHER

Hair loss

Muscle soreness

Flaky scalp

Food cravings

Achy joints

Other:

# self-care planner

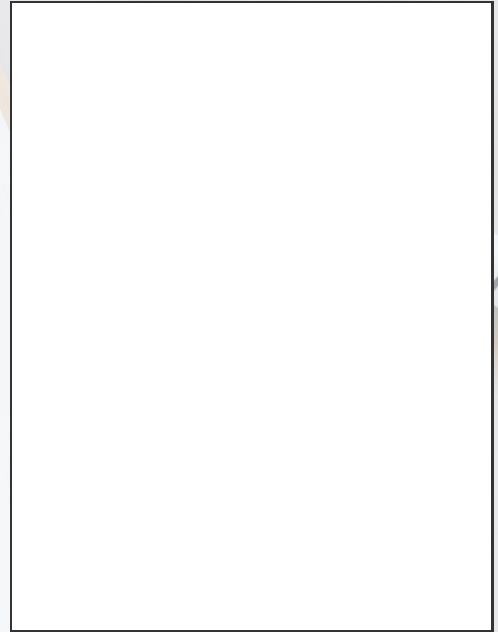
Monday



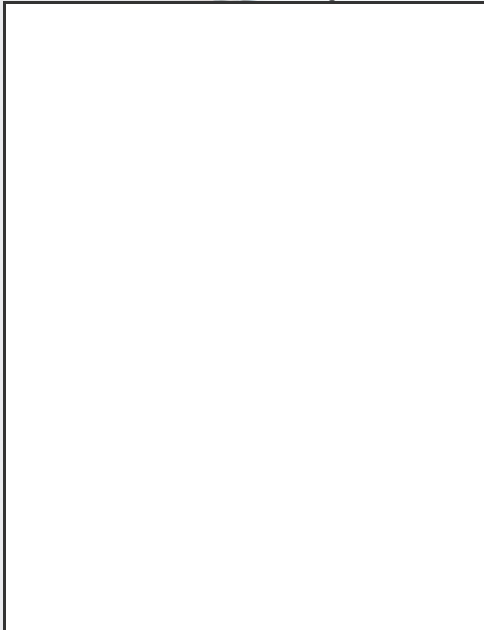
Tuesday



Wednesday



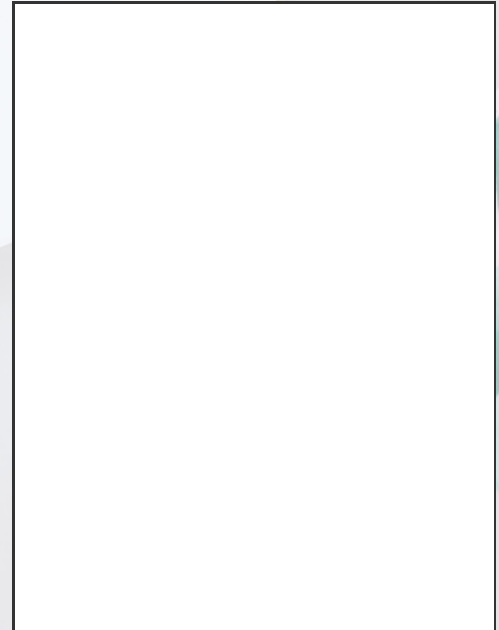
Thursday



Friday



Sat/Sun





# Month 2

Body, Mind, and Soul Transformation



# Month 2 check-in

RATE EACH SYMPTOM ACCORDING TO HOW YOU FELT THIS WEEK.  
USE THE FOLLOWING POINT SCALE:

0 = NEVER; 1 = SOMETIMES MILD; 2 = SOMETIMES SEVERE; 3 = FREQUENTLY MILD; 4 = FREQUENTLY SEVERE

## HEAD + MIND

- |  |   |
|--|---|
| <input type="checkbox"/> Headache                    | <input type="checkbox"/> Poor concentration |
| <input type="checkbox"/> Migraine                    | <input type="checkbox"/> Brain fog          |
| <input type="checkbox"/> Forgetfulness / poor memory | <input type="checkbox"/> Dizziness          |

## EYES + NOSE + SKIN

- |   |   |
|---|---|
| <input type="checkbox"/> Watery eyes            | <input type="checkbox"/> Sinus discomfort |
| <input type="checkbox"/> Blurred vision         | <input type="checkbox"/> Acne             |
| <input type="checkbox"/> Congested / runny nose | <input type="checkbox"/> Hives / rashes   |

## DIGESTIVE

- |                                    |                                       |
|------------------------------------|---------------------------------------|
| <input type="checkbox"/> Nausea    | <input type="checkbox"/> Diarrhea     |
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Bloat     | <input type="checkbox"/> Vomiting     |



# Month 2 check-in

RATE EACH SYMPTOM ACCORDING TO HOW YOU FELT THIS WEEK.  
USE THE FOLLOWING POINT SCALE:

0 = NEVER; 1 = SOMETIMES MILD; 2 = SOMETIMES SEVERE; 3 = FREQUENTLY MILD; 4 = FREQUENTLY SEVERE

## ENERGY + MOOD

- |                                      |   |
|--------------------------------------|---|
| <input type="checkbox"/> Fatigue     | <input type="checkbox"/> Anger / irritability |
| <input type="checkbox"/> Hyperactive | <input type="checkbox"/> Depression           |
| <input type="checkbox"/> Mood swings | <input type="checkbox"/> Anxiety              |

## SLEEP

- |  |   |
|--|---|
| <input type="checkbox"/> Difficulty falling asleep | <input type="checkbox"/> Restless legs      |
| <input type="checkbox"/> Difficulty staying asleep | <input type="checkbox"/> Leg cramping       |
| <input type="checkbox"/> Insomnia                  | <input type="checkbox"/> Daytime drowsiness |

## OTHER

- |                                      |  |
|--------------------------------------|--|
| <input type="checkbox"/> Hair loss   | <input type="checkbox"/> Muscle soreness |
| <input type="checkbox"/> Flaky scalp | <input type="checkbox"/> Food cravings   |
| <input type="checkbox"/> Achy joints | <input type="checkbox"/> Other:          |

# self-care planner

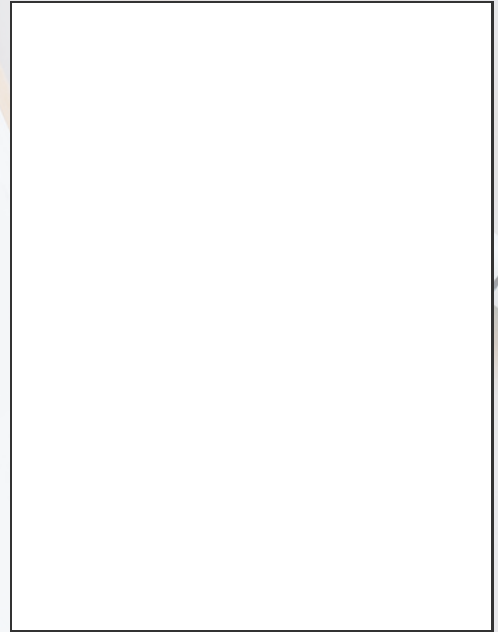
Monday



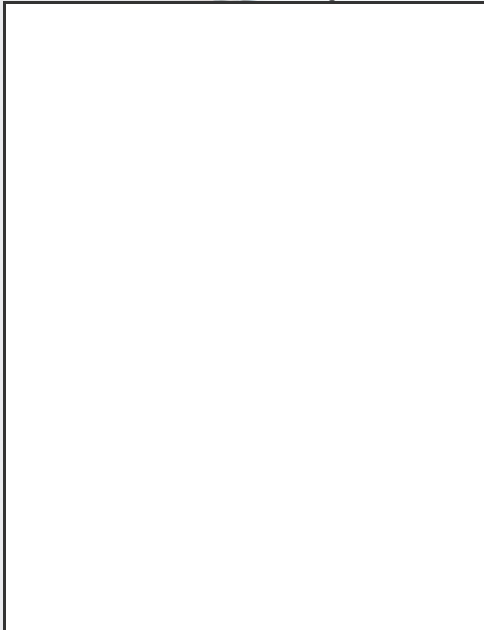
Tuesday



Wednesday



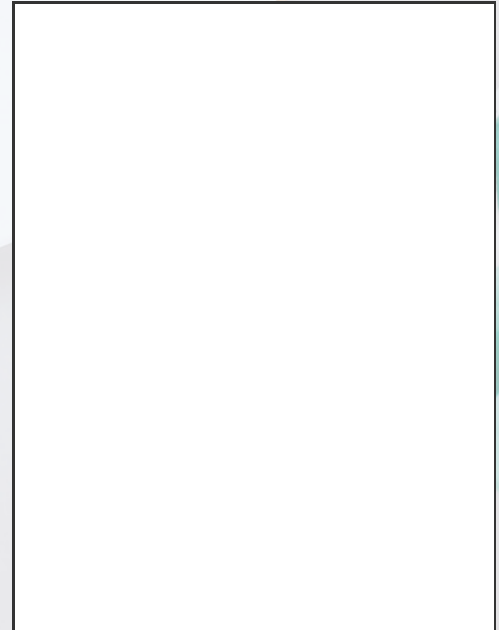
Thursday



Friday



Sat/Sun





# Month 3

Body, Mind, and Soul Transformation



# Month 3 check-in

RATE EACH SYMPTOM ACCORDING TO HOW YOU FELT THIS WEEK.  
USE THE FOLLOWING POINT SCALE:

0 = NEVER; 1 = SOMETIMES MILD; 2 = SOMETIMES SEVERE; 3 = FREQUENTLY MILD; 4 = FREQUENTLY SEVERE

## HEAD + MIND

- |                          |                             |                          |                    |
|--------------------------|-----------------------------|--------------------------|--------------------|
| <input type="checkbox"/> | Headache                    | <input type="checkbox"/> | Poor concentration |
| <input type="checkbox"/> | Migraine                    | <input type="checkbox"/> | Brain fog          |
| <input type="checkbox"/> | Forgetfulness / poor memory | <input type="checkbox"/> | Dizziness          |

## EYES + NOSE + SKIN

- |                          |                        |                          |                  |
|--------------------------|------------------------|--------------------------|------------------|
| <input type="checkbox"/> | Watery eyes            | <input type="checkbox"/> | Sinus discomfort |
| <input type="checkbox"/> | Blurred vision         | <input type="checkbox"/> | Acne             |
| <input type="checkbox"/> | Congested / runny nose | <input type="checkbox"/> | Hives / rashes   |

## DIGESTIVE

- |                          |           |                          |              |
|--------------------------|-----------|--------------------------|--------------|
| <input type="checkbox"/> | Nausea    | <input type="checkbox"/> | Diarrhea     |
| <input type="checkbox"/> | Heartburn | <input type="checkbox"/> | Constipation |
| <input type="checkbox"/> | Bloat     | <input type="checkbox"/> | Vomiting     |

# Month 3 check-in

RATE EACH SYMPTOM ACCORDING TO HOW YOU FELT THIS WEEK.  
USE THE FOLLOWING POINT SCALE:

0 = NEVER; 1 = SOMETIMES MILD; 2 = SOMETIMES SEVERE; 3 = FREQUENTLY MILD; 4 = FREQUENTLY SEVERE

## ENERGY + MOOD

- |                                      |   |
|--------------------------------------|---|
| <input type="checkbox"/> Fatigue     | <input type="checkbox"/> Anger / irritability |
| <input type="checkbox"/> Hyperactive | <input type="checkbox"/> Depression           |
| <input type="checkbox"/> Mood swings | <input type="checkbox"/> Anxiety              |

## SLEEP

- |  |   |
|--|---|
| <input type="checkbox"/> Difficulty falling asleep | <input type="checkbox"/> Restless legs      |
| <input type="checkbox"/> Difficulty staying asleep | <input type="checkbox"/> Leg cramping       |
| <input type="checkbox"/> Insomnia                  | <input type="checkbox"/> Daytime drowsiness |

## OTHER

- |                                      |  |
|--------------------------------------|--|
| <input type="checkbox"/> Hair loss   | <input type="checkbox"/> Muscle soreness |
| <input type="checkbox"/> Flaky scalp | <input type="checkbox"/> Food cravings   |
| <input type="checkbox"/> Achy joints | <input type="checkbox"/> Other:          |

# self-care planner

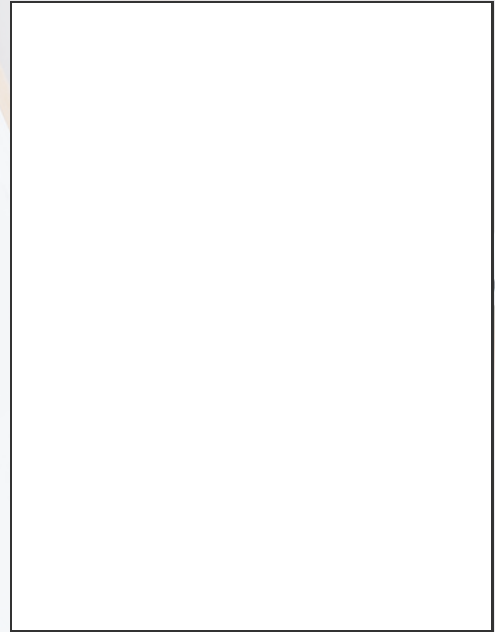
Monday



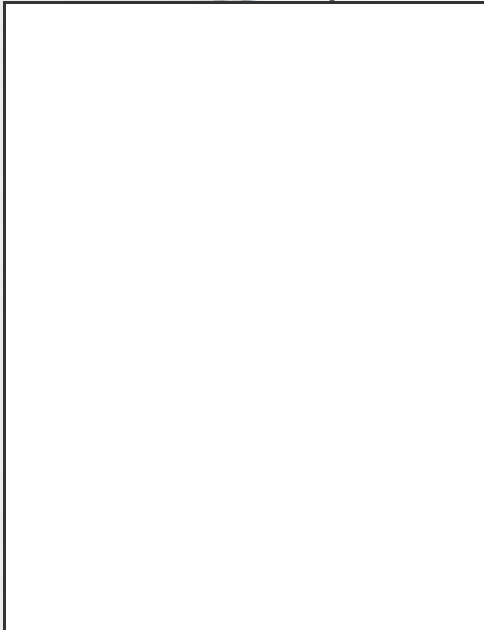
Tuesday



Wednesday



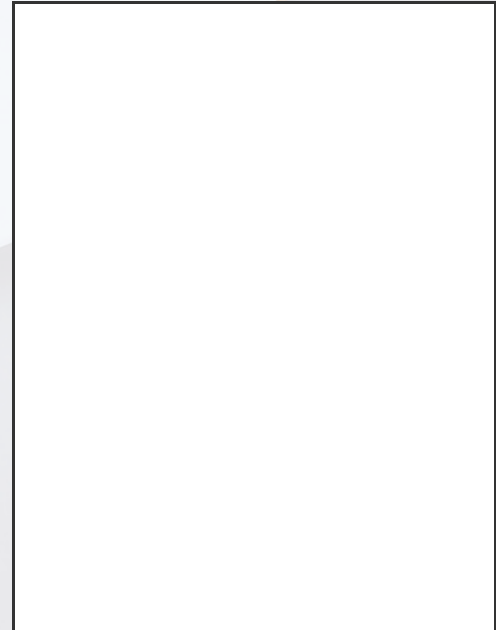
Thursday



Friday



Sat/Sun







# Month 4

Body, Mind, and Soul Transformation

# Month 4 check-in

RATE EACH SYMPTOM ACCORDING TO HOW YOU FELT THIS WEEK.  
USE THE FOLLOWING POINT SCALE:

0 = NEVER; 1 = SOMETIMES MILD; 2 = SOMETIMES SEVERE; 3 = FREQUENTLY MILD; 4 = FREQUENTLY SEVERE

## HEAD + MIND

- |  |   |
|--|---|
| <input type="checkbox"/> Headache                    | <input type="checkbox"/> Poor concentration |
| <input type="checkbox"/> Migraine                    | <input type="checkbox"/> Brain fog          |
| <input type="checkbox"/> Forgetfulness / poor memory | <input type="checkbox"/> Dizziness          |

## EYES + NOSE + SKIN

- |   |   |
|---|---|
| <input type="checkbox"/> Watery eyes            | <input type="checkbox"/> Sinus discomfort |
| <input type="checkbox"/> Blurred vision         | <input type="checkbox"/> Acne             |
| <input type="checkbox"/> Congested / runny nose | <input type="checkbox"/> Hives / rashes   |

## DIGESTIVE

- |                                    |                                       |
|------------------------------------|---------------------------------------|
| <input type="checkbox"/> Nausea    | <input type="checkbox"/> Diarrhea     |
| <input type="checkbox"/> Heartburn | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Bloat     | <input type="checkbox"/> Vomiting     |

# Month 4 check-in

RATE EACH SYMPTOM ACCORDING TO HOW YOU FELT THIS WEEK.  
USE THE FOLLOWING POINT SCALE:

0 = NEVER; 1 = SOMETIMES MILD; 2 = SOMETIMES SEVERE; 3 = FREQUENTLY MILD; 4 = FREQUENTLY SEVERE

## ENERGY + MOOD

- |                                      |   |
|--------------------------------------|---|
| <input type="checkbox"/> Fatigue     | <input type="checkbox"/> Anger / irritability |
| <input type="checkbox"/> Hyperactive | <input type="checkbox"/> Depression           |
| <input type="checkbox"/> Mood swings | <input type="checkbox"/> Anxiety              |

## SLEEP

- |  |   |
|--|---|
| <input type="checkbox"/> Difficulty falling asleep | <input type="checkbox"/> Restless legs      |
| <input type="checkbox"/> Difficulty staying asleep | <input type="checkbox"/> Leg cramping       |
| <input type="checkbox"/> Insomnia                  | <input type="checkbox"/> Daytime drowsiness |

## OTHER

- |                                      |  |
|--------------------------------------|--|
| <input type="checkbox"/> Hair loss   | <input type="checkbox"/> Muscle soreness |
| <input type="checkbox"/> Flaky scalp | <input type="checkbox"/> Food cravings   |
| <input type="checkbox"/> Achy joints | <input type="checkbox"/> Other:          |



# self-care planner

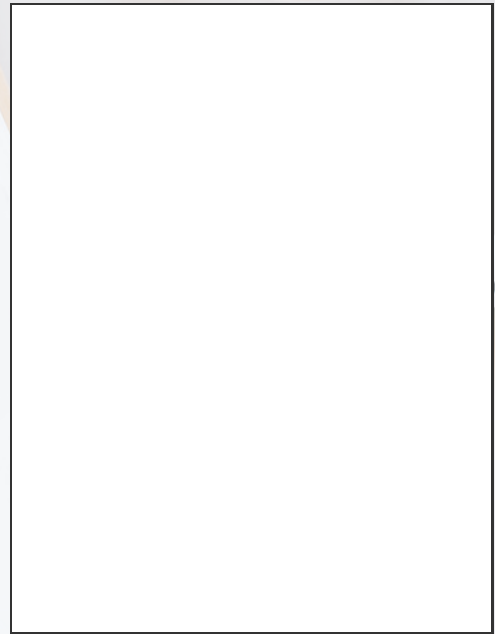
Monday



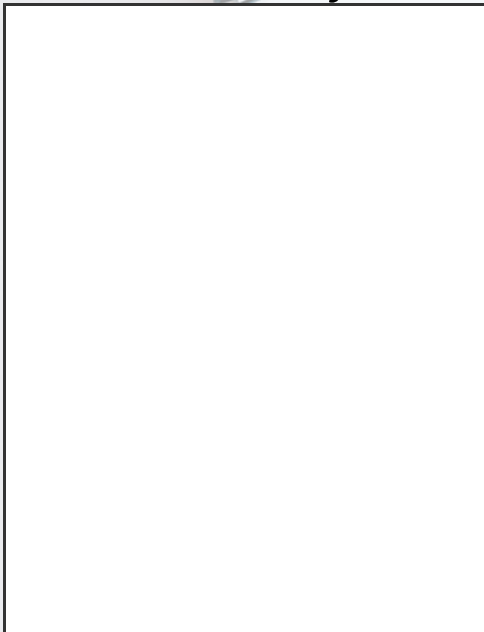
Tuesday



Wednesday



Thursday



Friday



Sat/Sun

