BOOK 1 of the S.H.E.P.S. METHOD SERIES

Your First 9 Months on GLP-1

The S.H.E.P.S. Method

How I Lost 50 Pounds and Built a System That Actually Works

Created by

Mark “Shep” Shepherd

Not medical advice. Always consult a licensed healthcare provider.

Your First 9 Months on GLP-1
The S.H.E.P.S. Method — How I Lost 50 Pounds and Built a System That Actually Works
Book 1 of the S.H.E.P.S. Method Series
Created by Mark "Shep" Shepherd

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Published in the United States by The GLP-1 Guide.
TheGLP1Guide.net

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First edition.

Important — Please Read

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Always consult a licensed healthcare provider before starting, stopping, or changing any medication, supplement, or exercise routine. GLP-1 medications such as Ozempic, Wegovy, Mounjaro, and Zepbound are prescription drugs with serious potential side effects and contraindications. Your physician knows your medical history and is the only person qualified to advise you on your treatment.

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For my wife, Kate, and daughter, Alison.

And for every person who was told they just needed more willpower.

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A LETTER FROM SHEP

Before We Begin

Hi. I'm Shep.

Before I say anything about medications, muscles, or protein grams, let me tell you the simple thing that matters: I was you.

I spent thirty-five years in medical device sales — 30 of them selling to ENT doctors, and the last 26 years with Medtronic, the largest medical device company in the world, where I earned Rep-of-the-Year for the U.S. twice while covering Northern California. I worked in the operating room with ENT surgeons and nurses in small hospitals and large teaching hospitals.

What I never told the doctors I worked with was that underneath the suit, I was heavier every year. By my fifties I had added fifty pounds since college. I was the guy in the hospital hallway who could sell them the newest device but could not fix the thing staring back at me in the mirror.

At my heaviest in my fifties I weighed more than I ever had in my life. My back hurt, my body ached, and my snoring kept my wife awake at night. My blood pressure was creeping up, my A1c was creeping up, and my doctor had started using the word "pre" in front of things I did not want to be pre anything about.

I had tried every diet. I had tried the shakes, the points, the fasting windows, the keto experiments, the "one day at a time" pep talks, and three separate gym memberships that I paid for more than I used. I was not lazy. I was not undisciplined. I knew how to execute a plan. What I did not know was that my biology was fighting me in a way no plan on a piece of paper could beat.

I retired in May of 2024 at fifty-seven. I told myself retirement would be when I finally got serious about my health. It wasn't. A year went by. The weight stayed. The snoring got worse. The labs got worse. In July of 2025 I sat down with my doctor and — with her guidance — I started a GLP-1.

In the nine months since that first injection — on the medication plus the five habits I'm going to walk you through in this book — I lost fifty pounds. Not in a dramatic before-and-after photograph way. In a quiet, daily, "I actually feel like myself again" way.

Here is what I learned, and it is the entire reason this book exists: the medication is not the whole answer. The medication is the door. What you do on the other side of the door — how you sleep, how you hydrate, how you strength train, how you eat protein, and how you support the rebuild

with the right supplements — is what makes the loss stick, protects your muscle, and protects the person you're becoming.

That is the S.H.E.P.S. Method. Five letters. Five habits. Built for the GLP-1 era, built by a patient, for readers.

I am not a doctor. I want to say that right now, loudly, so you hear it in every chapter. I am a retired sales rep who happens to have spent three and a half decades listening to doctors explain things and then translating those explanations for people who were scared, tired, and out of options. Every clinical decision in this book — dose, medication, labs, supplements — belongs between you and your licensed provider. My job is to hand you the map.

This is not a phone book. This is a Healthy Lifestyle Support System.

Turn the page. Let's go.

— Shep

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Want the rest?

Not medical advice. Always consult a licensed healthcare provider.

How to Use This Book

Read it through once, start to finish.

The book is built in a deliberate order: why these medications work, then the five habits, then your first ninety days, then where I am today. Each part sets up the next. Read it linearly the first time so nothing feels out of context.

Then use it as a reference.

After the first read, you will come back to specific chapters. The protein rule in Chapter 8. The recovery script in whichever habit just fell off last weekend. The tracking system in Chapter 14. That is how this book is meant to be used — kept close, dog-eared, written in.

Skim the callout boxes if you're in a hurry.

Every chapter has at least one boxed rule or checklist. If you only have five minutes, read those. Then come back for the rest later.

Do the 1-Week Starter Plans in order.

Each of the five S.H.E.P.S. chapters ends with a seven-day mini-plan. Do SLEEP first. Then HYDRATION. Then EXERCISE. Then PROTEIN. Then SUPPLEMENTS. Stacking in that order is on purpose — each one makes the next one easier.

Bring it to your doctor.

The back matter has a First GLP-1 Appointment Checklist and Ten Questions to Ask Your Provider. Rip them out. Hand them over. A good provider will thank you for coming prepared.

Write in the margins.

Your weight. Your waist. The date you started. The day you had your first good sleep in a year. The meal where you hit thirty grams of protein without thinking about it. This book is a tool, not a trophy. Use it hard.

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Part I

Why GLP-1s Work

The four medications, the biology behind them, and why willpower was never the bottleneck.

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CHAPTER 1

The Four Molecules That Changed Weight Loss

Four medications, two companies, one biological insight that finally cracked the code.

Not medical advice — work with your provider on anything that changes your protocol.

I sold medical devices for thirty-five years and I never saw the field move this fast.

The short version

There are, as of this writing, four GLP-1 medications that you are most likely to hear about, see on television, or be prescribed. Two are made by Novo Nordisk. Two are made by Eli Lilly. They are called Ozempic, Wegovy, Mounjaro, and Zepbound. Knowing what each one is — and what it is approved for — is the first thing a patient should learn, because brand names get used loosely in conversation and it can get confusing fast.

Let me walk you through them the way I would have walked an ENT doctor through a new device twenty years ago: plain language, no marketing, what it does, who it's for.

Ozempic and Wegovy (semaglutide) — Novo Nordisk

Ozempic and Wegovy are the same molecule, semaglutide, sold under two different labels for two different FDA-approved uses. Ozempic is approved for adults with type 2 diabetes, to improve blood sugar control alongside diet and exercise, and in some patients to reduce the risk of major cardiovascular events. Wegovy is approved specifically for chronic weight management in adults and, more recently, in adolescents twelve and older who meet certain criteria.

Same active ingredient, different brand, different approved population. That is why you'll hear a doctor say something like "we're going to use semaglutide" and then the pharmacy fills Wegovy or Ozempic depending on your diagnosis and your insurance. It is also why a news headline about "Ozempic" is usually really a story about semaglutide broadly.

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Mounjaro and Zepbound (tirzepatide) — Eli Lilly

Mounjaro and Zepbound are also the same molecule, tirzepatide, sold under two labels for two approved uses. Mounjaro is approved for adults with type 2 diabetes. Zepbound is approved for chronic weight management in adults who meet BMI-based criteria, with or without an additional weight-related condition.

Tirzepatide is sometimes called a "dual agonist" because it acts on two receptors in the body — GLP-1 and GIP — instead of one. In the clinical trials, tirzepatide produced larger average weight loss than semaglutide. Your doctor will decide which is right for you based on your history, your other conditions, side-effect profile, and what your insurance actually covers, which in the real world is often the deciding factor.

The others you'll hear about

A few more names show up in the GLP-1 conversation and are worth knowing so you are not caught off guard.

Rybelsus is oral semaglutide — a pill version, made by Novo Nordisk, approved for type 2 diabetes. Same molecule as Ozempic and Wegovy, delivered differently. Saxenda is liraglutide, an older daily injection also from Novo Nordisk, approved for chronic weight management. Trulicity is dulaglutide, a weekly injection from Eli Lilly approved for type 2 diabetes.

You will hear people on the internet use "Ozempic" as shorthand for all of them. Don't. When you talk to your doctor, use the real name of what you are on — or what you are asking about — because the differences matter.

> ### The four names to know
>
> Ozempic (semaglutide, Novo Nordisk) — type 2 diabetes.
> Wegovy (semaglutide, Novo Nordisk) — chronic weight management.
> Mounjaro (tirzepatide, Eli Lilly) — type 2 diabetes.
> Zepbound (tirzepatide, Eli Lilly) — chronic weight management.

Why this matters for you, the patient

Three reasons you should know which molecule you are actually on.

First, because dose titration schedules are different between semaglutide and tirzepatide. If you don't know which one you are taking, you cannot read the label intelligently or have a coherent conversation about moving up or down a step.

Not medical advice. Always consult a licensed healthcare provider.

Second, because side-effect profiles are slightly different between molecules and even between patients on the same molecule. Your doctor needs you to report specifically: "I'm on Zepbound, week three, at this dose, and here's what I'm feeling."

Third, because insurance coverage swings wildly by brand, by plan, by year, and by whether your diagnosis is diabetes or obesity. Being fluent in the brand names is the first step to advocating for yourself in that fight.

> *"The medication is the door. What you do on the other side of the door is what makes the loss stick."*
>
> — Shep

What this book is not

This book is not going to tell you which medication to take. That is a decision for you and your licensed prescriber, based on your labs, your medical history, your goals, and your coverage. What this book will do is teach you the five habits — Sleep, Hydration, Exercise, Protein, Supplements — that turn any of these medications into a long-term result instead of a short-term event.

In the next chapter I'll walk through how GLP-1 receptors actually work in your body, in plain English, so you understand why the medication does what it does and why the five habits amplify it.

A brief history, because context matters

GLP-1 as a hormone was described scientifically in the early 1980s. For twenty years after that, it sat in journals. The first GLP-1 receptor agonist medication approved for human use was exenatide — brand name Byetta — in 2005, for type 2 diabetes. It required twice-daily injections. Nobody outside the diabetes community noticed.

Liraglutide (Victoza, then Saxenda) arrived around 2010 with once-daily dosing. It was the first GLP-1 to get an obesity indication, as Saxenda. Still niche. Still a daily injection. Dulaglutide (Trulicity) came soon after with once-weekly dosing for diabetes.

Then semaglutide changed the conversation. Ozempic in 2017 for diabetes. Wegovy in 2021 for weight management. The combination of once-weekly dosing, a pen injector that felt almost trivial to use, and — critically — weight-loss percentages in the studies that nobody had seen outside surgery took the category mainstream in a way none of its predecessors did.

Tirzepatide arrived in 2022 as Mounjaro for diabetes and in late 2023 as Zepbound for weight management. It is the first dual-receptor agonist on the market and, in head-to-head trial

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comparisons, has produced larger average weight loss than semaglutide. There are more molecules in the pipeline — triple agonists, oral formulations, combinations — and this space is going to keep moving.

What about compounded versions

You have probably seen ads for compounded semaglutide or compounded tirzepatide at prices well below the brand-name versions. A compounded medication is one prepared by a licensed pharmacy using the active ingredient rather than dispensed from a manufacturer's bottle. Under certain FDA rules — particularly when a medication is on the official shortage list — compounding pharmacies can legally prepare versions for individual prescriptions.

I am not going to tell you whether to use a compounded version. What I will tell you: that decision belongs between you, your prescriber, and a reputable pharmacy with a real license you can verify. The FDA has repeatedly warned about online sellers marketing "research peptides" and unregulated products that are not the same molecule, not the same purity, and not the same dose consistency as the approved brands. Be careful. Ask questions. Your body is not a place to save money the wrong way.

A short glossary to carry forward

Semaglutide — the molecule in Ozempic, Wegovy, and Rybelsus.
Tirzepatide — the molecule in Mounjaro and Zepbound.
Liraglutide — the molecule in Saxenda and Victoza.
Dulaglutide — the molecule in Trulicity.
GLP-1 agonist — a medication that acts on the GLP-1 receptor.
GIP/GLP-1 dual agonist — tirzepatide; acts on two receptors.

Insurance, coverage, and the reality of cost

Here is a sentence I wish someone had told me before my first appointment: the biggest single predictor of whether you stay on your GLP-1 long enough to see results is not the medication — it's whether you can afford it. List prices on these medications are over a thousand dollars per month in the United States. Most people do not pay list price, but the gap between "covered" and "out of pocket" can be the difference between a successful year and a stopped treatment.

Three things to verify before you leave your first appointment. One: is the medication your doctor prescribed on your insurance formulary, and at what tier. Two: is a prior authorization required, and if so, what documentation does your doctor need to submit. Three: are there manufacturer savings cards or patient assistance programs you qualify for. The manufacturer websites for Ozempic, Wegovy, Mounjaro, and Zepbound keep current information on these programs.

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CHAPTER 2

How GLP-1 Receptors Actually Work

Plain English on hunger signals, gastric emptying, and why cravings go quiet.

I am not a physiologist. But I sat in a lot of medical education sessions, and this is how it was explained to me.

Start with what GLP-1 is

GLP-1 stands for glucagon-like peptide-1. It is a hormone your own body makes, in your gut, every time you eat. Its job — one of its jobs — is to tell your pancreas to release insulin, tell your stomach to slow down, and tell your brain that you are full. It is part of your natural satiety system. You have been making GLP-1 your whole life.

The medications we talked about in Chapter 1 are GLP-1 receptor agonists. "Agonist" is a fancy word for "a key that fits the lock and turns it." These drugs are engineered molecules that look enough like your body's own GLP-1 to fit the same receptor — but they last in the bloodstream for days instead of minutes. That is the whole trick. Your body's own GLP-1 is gone in about two minutes. Semaglutide and tirzepatide hang around for days.

Three things happen when that receptor is turned on

One: your stomach empties more slowly. Food sits longer. You feel full after less. The physical sensation of fullness — that "I couldn't eat another bite" feeling you used to only get at Thanksgiving — shows up after a normal-size meal. For a lot of people, this is the single most noticeable change in the first two weeks.

Two: your pancreas becomes more efficient. When you eat, insulin is released in better timing with the glucose spike. Blood sugar swings smooth out. This is why the same medication is approved for type 2 diabetes — it is quite literally doing the job of a blood-sugar regulator.

Three — and this is the one that surprises people the most — the constant background noise of food thoughts gets quieter. People call it "food noise." The running commentary in your head about what you're going to eat next, the pull toward the pantry at nine at night, the mental negotiation every time you walk past a bakery. A lot of people on GLP-1 describe this going from a loud radio to a whisper. Some describe it going nearly silent. That is not imagination. GLP-1 receptors live in reward and appetite centers of the brain, and turning them up dials the noise down.

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What a GLP-1 is actually doing

Slowing gastric emptying (you feel fuller, longer).
Improving insulin timing (blood sugar stabilizes).
Quieting appetite and reward signaling in the brain (food noise drops).
All three together — not one — are why the weight comes off.

Why this is different from a diet

Here is the sentence that, when I finally heard it from an endocrinologist I respect, changed how I thought about my own weight: "A diet asks a hungry person not to eat. A GLP-1 asks a person who isn't hungry if they want to eat."

That is the entire mechanism in one line. Every diet I had ever tried was asking my brain to override a biology that was screaming. The medication turns down the screaming. That is not cheating. That is the first time the playing field is level.

> *"A diet asks a hungry person not to eat. A GLP-1 asks a person who isn't hungry if they want to eat."*
>
> — Shep

What GLP-1s do not do

They do not build muscle. They do not pick your groceries. They do not know if you slept last night. They do not hydrate you. They do not make you lift weights. All of those jobs are still yours. That is why the five habits in Part II exist — because the medication clears the biological interference, and the habits fill the space with the right signals.

They also do not work forever on their own. If you stop the medication and nothing else in your life has changed, the appetite signals come back. We'll cover what to do about that in Chapter 15. But the short version is: the Method is what holds the loss when the medication changes.

A word about the gut

Because these medications slow down the stomach, almost everything in the first month of side effects — nausea, fullness, occasional reflux, constipation — traces back to that one mechanism. It is not random. Chapter 4 will walk through what is normal, what to do about it, and when to call your doctor.

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Why the effect is felt in the brain as much as the gut

When I first read that GLP-1 receptors exist in the brain, it surprised me. I had always thought of these medications as "stomach drugs" — slow digestion, less appetite, end of story. The brain piece is actually the bigger piece.

Your hypothalamus has GLP-1 receptors. So do parts of your brainstem that regulate nausea and fullness. So do areas of the reward system — the same circuitry that responds to food, alcohol, and other things we can become attached to. When the medication activates those receptors, the signals to eat, to seek, to "just one more bite" get quieter across the board. Anecdotally, many people on GLP-1 report drinking less alcohol without trying. Some report reduced interest in things they used to compulsively check. Researchers are still studying this. The reports are consistent enough that I'd bet on it holding up.

The difference between "not hungry" and "full"

Learn this distinction and put it into your vocabulary. "Not hungry" is how you start a meal on GLP-1 — the absence of the pull. "Full" is how you end a meal faster than you used to — the presence of satiety.

The reason this matters: the two signals require different responses. Not-hungry is when you still eat — a protein-first plate of food, on schedule, because you need the nutrition and your body is not going to remind you. Full is when you stop — one or two bites earlier than you would have six months ago, because the physical sensation is real and ignoring it is how people on GLP-1 end up nauseated.

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CHAPTER 3

Why Willpower Isn't the Problem

The science of the set point, and why every diet before this one was rigged.

I spent twenty years blaming myself for something my biology was doing on purpose.

The set point, in one paragraph

Your body has a weight it thinks it is supposed to be. Not the weight you want. Not the weight on your driver's license. The weight your hypothalamus has decided, based on years of signals, is "normal" for you. When you drop below that weight through dieting, your body does not say "great job." Your body says "emergency" and starts turning knobs to get you back. Hunger hormones up. Metabolism down. Every diet you've ever been on was a fight against that thermostat, and the thermostat usually won.

Leptin — the fullness hormone that stops listening

Leptin is a hormone your fat cells release to tell your brain you have enough stored energy. In theory, the more fat you have, the more leptin you have, the less hungry you should be. In practice, with chronic excess weight, the brain becomes resistant to leptin. It stops hearing the signal. You can have plenty of stored energy and still feel hungry all the time. This is not a character flaw. This is a broken signaling loop.

When you lose weight by dieting alone, leptin drops — because you have less fat — and the brain, which was already not hearing the signal well, now hears even less of it. Hunger roars back. This is why most diets end the same way. Not because you lacked discipline. Because your hormones ran out of patience before you did.

Ghrelin, the hunger hormone that won't quit

Ghrelin is leptin's opposite. It goes up before meals to make you hungry and drops after you eat. In people who have dieted hard, ghrelin stays elevated — sometimes for years after the diet ended. That constant low-grade hunger you felt after losing thirty pounds and then gaining it back? That was ghrelin, still doing its job, still yelling at you to eat.

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Why GLP-1s break the cycle

GLP-1 medications work upstream of all this. They don't argue with leptin resistance. They don't try to outshout ghrelin. They act on a different pathway — the one your body uses naturally, the one a bariatric surgery patient's gut produces in huge quantities after the operation. They give your brain a signal it was supposed to get every day and, for whatever combination of reasons, wasn't getting enough of.

This is why, for so many people, a GLP-1 feels less like a diet and more like the first time a door opened. The signal your biology was supposed to provide is finally being provided.

> ### Read this line twice
>
> You did not fail every diet. Every diet failed to address the hormonal system that was keeping your set point high.
>
> That is not an excuse. It is a diagnosis. And it is the first honest explanation a lot of people have ever gotten.

Why the five habits still matter

If biology is this much of the story, you might wonder why Sleep, Hydration, Exercise, Protein, and Supplements matter at all. Here is why. The medication resets the signal. The habits reset the environment around the signal.

Sleep regulates ghrelin and leptin directly. Hydration supports every system the medication is now asking to work harder. Exercise — specifically Strength / Resistance training — preserves the muscle that would otherwise come off with the fat and make the loss less healthy than it looks. Protein gives the muscle the raw material to exist. Supplements fill the gaps that show up when you're eating less food overall.

You are not "doing the work" to earn the medication. You are doing the work to protect the rebuild.

> *"You did not fail every diet. Every diet failed to address the biology."*
>
> — Shep

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What this means for how you talk to yourself

I am going to ask you to do one thing right now, before you read another chapter. Drop the word "willpower" from the way you describe your own weight story. Not because willpower isn't real — it is — but because using it as the main frame has been a lie we told ourselves for fifty years. You have plenty of willpower. You ran businesses, raised children, showed up to jobs, buried people you loved. That is discipline. It just was not the bottleneck.

The bottleneck was biology. The biology now has a tool. Your job, starting in Part II, is to build the lifestyle around the tool.

What the research community now says out loud

For thirty years, the standard line in weight-loss literature was "calories in, calories out." It is not wrong — thermodynamics is still thermodynamics. What has changed is the acknowledgment of all the ways your body quietly adjusts both sides of that equation when you try to cut one of them.

Cut calories and your resting metabolism drops. Lose ten percent of your body weight by dieting alone and your basal metabolic rate can drop beyond what the weight loss alone would predict. This is called metabolic adaptation and it is real and it is not your fault. It is your hypothalamus doing the job evolution built it for: protecting you from starvation. The problem, of course, is that your hypothalamus does not know that your set point is too high for your health. It only knows that you're dropping weight, and that this is concerning.

GLP-1 medications work on a pathway that is less subject to this adaptation. Not immune — nothing is immune — but the down-regulation that ends most diets is markedly less pronounced with a GLP-1, which is why weight loss trajectories on these medications tend to be longer and more sustained than on diet alone.

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CHAPTER 4

Side Effects: What To Expect, What To Do

The first four weeks, honestly — and the short list of things that should send you to the phone.

Not medical advice — work with your provider on anything that changes your protocol.

Nothing prepared me for Week 2 nausea. So let me prepare you.

The short version

Most people on GLP-1 feel something in the first four weeks. Nausea is the most common. Fatigue is second. Constipation is close behind. A smaller group gets reflux, early fullness that feels uncomfortable, or occasional vomiting after overeating. For the vast majority, these settle down as the body adjusts, especially if you're titrating slowly under a doctor's supervision.

None of this means the medication is "not for you." It means your body is adjusting to a signal it has not had at this intensity before. Talk to your doctor about every symptom you have. The list below is what I experienced myself and what I have read most often in the GLP-1 literature and communities — not medical advice.

Week 1 to 2 — the settling in

Most people feel the medication within the first few days. For me, it showed up as a quiet I hadn't noticed was missing — I would look at the clock at seven PM and realize I hadn't thought about food since lunch. That was new.

What also showed up: mild nausea, especially a few hours after the injection. A slower appetite at dinner. A couple days where I felt more tired than usual. For some people there is mild headache, for some a stomach that feels "off." You may even have a day with some diarrhea. Don't panic. Your body is just adjusting, or you ate something too spicy for the time being. Remember, your digestion is slowing down. Small meals, more water, and the electrolyte protocols in Chapter 6 usually handle most of it.

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Week 3 to 4 — the learning curve

By week three your body has some familiarity with the signal. If your doctor titrates you up, you may get a fresh round of milder versions of the week-one symptoms. Constipation becomes a more common complaint here — because you are eating less, moving food more slowly, and often drinking less than you think.

This is the window where a lot of people start to feel how real the change is. Clothes fit differently. You get full on half a plate. You don't raid the pantry at night. It is also the window where getting the five habits in place starts to matter the most — because the medication is now doing its part, and the question becomes whether the rest of your life is supporting the rebuild.

The short list of "call your doctor" symptoms

Severe abdominal pain, especially upper-middle or radiating to the back.
Vomiting that won't stop, or signs of dehydration.
Yellowing of the skin or eyes.
A lump or swelling in the neck, or persistent hoarseness.
Rapid heartbeat, severe dizziness, or fainting.
Any new symptom that scares you. That last one is not a joke. Call.

What helps, in practice

Eat smaller meals. Half of what you would have eaten six months ago is often the right amount now. Protein first, then vegetables, then starch. Greasy and heavily fried food will backfire harder than you think. Carbonation may go from enjoyable to uncomfortable. Alcohol tolerance may drop noticeably.

Drink water deliberately — not just when you're thirsty, because thirst signaling can get quieter too. Chapter 6 has the specific rule. I strongly encourage you to use an electrolyte packet in your water in the morning. Be proactive with your habits. Electrolytes will also help you from feeling dizzy from being unknowingly dehydrated.

For constipation, the standard answer is more fiber, more water, and some gentle magnesium at night — which we'll talk about in Chapter 9. If nothing is moving after three days, call your doctor before you self-treat.

For fatigue, respect it. This is not the week to start a new exercise program at full volume. Walk. Lift light. Sleep. The Method gives you a full chapter on sleep because it is the single most underrated side-effect fix in the first month.

Not medical advice. Always consult a licensed healthcare provider.

> *"Respect the first month. Your body is learning. So are you."*
>
> — Shep

When to stop worrying

For most patients, the side-effect curve peaks in the first two weeks after starting and after each dose increase, then settles. By the end of month one, people typically describe a new normal — less food, more fullness, steadier energy, less food noise. If at any point you are not getting to that new normal, or symptoms are getting worse instead of better, that is a conversation with your prescriber, not an internet search.

With the medication properly in place and side effects respected, Part II is where your real work begins.

A short list of myths worth ignoring

"Everyone who takes a GLP-1 throws up." No. Vomiting is a side effect. It is not universal. On a properly titrated dose, vomiting is usually either absent or rare, and when it does happen, it is most often traceable to eating too much or eating something greasy.

"These medications cause permanent changes to your stomach." There is no evidence of this at typical doses, in healthy adults, with appropriate monitoring. What these medications do is slow gastric emptying while you're on them. When you come off, your stomach motility returns to something like its prior baseline over weeks.

"If you take a GLP-1, you can eat whatever you want." Technically true that the medication doesn't care what's on your plate. Practically? If you eat junk, you'll feel awful. The quality of what you eat on GLP-1 becomes more noticeable, not less. Greasy food backfires harder. Sugar hits differently. Your body — which you can now hear — will tell you.

> *"The medication doesn't care what you eat. Your body absolutely does."*
>
> — Shep

The injection itself

If you are needle-phobic, you are not alone, and you are not stuck. The pen injectors for Ozempic, Wegovy, Mounjaro, and Zepbound are all designed to be essentially painless. The needle is shorter than you think. You click a button. You count to five or so. You're done.

Rotate sites — abdomen, thigh, upper arm, different spot each week. Pinch an inch of skin, insert at ninety degrees, click, count. If you have any confusion at all, call your pharmacist. They have walked through this thousands of times and will happily walk you through yours.

Not medical advice. Always consult a licensed healthcare provider.

What people wish they'd known in week one

When I read through the posts and comments in GLP-1 communities at month three, month six, and month twelve, the same short list of "I wish I had known" items comes up again and again. Here it is.

"I wish I hadn't fought the fullness." The number one rookie mistake is eating a full pre-medication portion because you told yourself you should. Your body is giving you a new signal. Listen to it. A half portion that lands well is worth more than a full portion that you vomit back up at 2 AM.

"I wish I'd drunk more water sooner." Nearly every person who will answer the question honestly says this one.

"I wish I'd taken pictures at the start." You do not know, at the start, how much you will change. When you do change, you will want a reference photo. Take one on day one. Front, side, back. Same spot. Same clothes. You will thank yourself in six months.

"I wish I had told my doctor about every symptom." Do not edit. Do not minimize. Do not think "this is probably nothing." Your doctor is there to decide what is something and what is nothing. Your job is to report accurately.

Not medical advice. Always consult a licensed healthcare provider.

Part II

The S.H.E.P.S. Method

Five letters. Five habits. Built for the GLP-1 era.

S is for **SLEEP**
H is for **HYDRATION**
E is for **EXERCISE**
P is for **PROTEIN**
S is for **SUPPLEMENTS**

Do them in that order. Each one makes the next one easier.

This is not a phone book.
This is a Healthy Lifestyle Support System.

Not medical advice. Always consult a licensed healthcare provider.

Chapter 5

S is for SLEEP

Sleep is the cheapest, most underrated GLP-1 amplifier you have.

Not medical advice — work with your provider on anything that changes your protocol.

My first fifteen pounds came off in the bedroom, not the kitchen.

Not medical advice. Always consult a licensed healthcare provider.

Why sleep matters more on GLP-1

Sleep is the first letter on purpose. Before we touch your water bottle, your dumbbells, your refrigerator, or your supplement drawer, we are going to fix how you sleep — because every other letter in this method works better, faster, and more forgivingly when you are sleeping seven hours or more a night.

Here is the short physiology. Sleep regulates ghrelin and leptin directly — the two hormones we met back in Chapter 3. One night of bad sleep raises ghrelin and lowers leptin the next day. That means more hunger and less fullness, even if your behavior is identical. On GLP-1, you are already fighting to eat enough good food in the window where you can eat; short sleep makes that window messier and your cravings louder, even in the quieter food-noise environment the medication creates.

Sleep also regulates cortisol, which regulates belly fat storage, which regulates insulin sensitivity. This is the feedback loop that every nutritionist and endocrinologist I ever sat across from eventually came back to: you cannot outwork bad sleep with a food log. And you cannot fully lean on GLP-1 to fix it. Sleep is its own job.

Shep's first fifteen pounds

Here is the honest truth of my first three months. I expected the medication to do the dramatic work and the habits to be nice-to-haves. It went the other way around, in one specific area.

By week four on my first dose, I had lost a few pounds — about what you'd expect. What I noticed more was that for the first time in probably five years, I was sleeping through the night. Not perfectly. But six hours with maybe one trip to the bathroom, instead of three hours of broken, restless, get-up-and-check-the-phone sleep. I was waking up less hungry. I was less interested in the pantry at nine PM.

By month three, I had lost about fifteen pounds, and my doctor asked me what I had changed. I said honestly — I was sleeping. She looked at me and said, "Shep, that may be half the weight." I don't know if it was half. But I know that when I kept a rough journal of the weeks I lost the most and the weeks I stalled, the single most predictive variable was not calories. It was sleep hours.

> *"My first fifteen pounds came off in the bedroom, not the kitchen."*
>
> — Shep

Not medical advice. Always consult a licensed healthcare provider.

The seven-hour floor

The rule in this chapter is simple. Seven hours minimum in bed with eyes closed, every night, as a target. Eight is better for most adults. If you are chronically getting five or six, you are not lazy — you are probably operating on a sleep debt that is quietly undoing everything the medication is trying to do.

"But I've always been a six-hour person." No, you've always been a six-hour person who adapted. That is not the same as thriving. Give seven hours a four-week trial. Measure your waist, your energy, and the scale at the end. I have watched a dozen people in my circle run this experiment and I have never once heard someone say "the extra hour wasn't worth it."

The four levers

There are four things that reliably move the needle on sleep quality. They are boring. They also work.

Temperature. Your bedroom should be cooler than your living room. Sixty-five to sixty-eight degrees Fahrenheit is the classic range. Your core temperature needs to drop to fall asleep; a warm room fights that.

Screens. The last thirty minutes before bed, no phone in the hand, no laptop in the lap, no television in the face. I know. Try it anyway for one week.

Caffeine. Cut it off by early afternoon. Caffeine has a half-life of five to six hours for most adults. A four-PM coffee is still doing real work at ten PM, whether you feel it or not.

Magnesium glycinate. We'll talk about this in more detail in Chapter 9. For most adults, 200 to 400 mg of magnesium glycinate in the evening helps the nervous system downshift and helps the bowel move the next morning. Talk to your doctor before adding it if you take other medications.

> ### The sleep rule for this method
> Seven hours minimum in bed, eyes closed. Target eight.
> Cool, dark room. Phone outside the bedroom or face-down across it.
> No caffeine after two PM.
> Magnesium glycinate in the evening, with your doctor's OK.

1-Week Sleep Starter Plan

One change a day. Stack them. By Sunday night you have a sleep-supporting environment that will pay dividends for the rest of the method.

Not medical advice. Always consult a licensed healthcare provider.

- ☐ Day 1 — Set a fixed bed time and a fixed wake time. Write them down.
- ☐ Day 2 — Move your phone charger out of arm's reach of the bed.
- ☐ Day 3 — Turn your thermostat down two degrees at night.
- ☐ Day 4 — Cut caffeine off at two PM. No exceptions this week.
- ☐ Day 5 — Add magnesium glycinate 30 minutes before bed (with doctor's OK).
- ☐ Day 6 — 30-minute screen-free wind-down. Book, shower, stretch, journal.
- ☐ Day 7 — Review the week. Keep what worked. Adjust one thing and continue.

Recovery script — when you fall off

You will. A late flight. A sick kid. A bad stretch of news. A work week from hell. When a sleep-disrupting event happens, run this script the next day, without negotiation.

- ☐ Wake at your normal time — do not sleep in more than 45 minutes.
- ☐ Get ten minutes of daylight within the first hour of waking.
- ☐ Back in bed at your normal bedtime tonight, even if it feels early.

That is it. Three steps. The goal is not to "catch up" — you cannot catch up on sleep on a schedule. The goal is to re-anchor your rhythm as fast as possible so one bad night does not become a bad week.

Sleep in the first month on GLP-1 — what changes

In the first month, a lot of people notice that their sleep changes in two directions at once. On the positive side — and this is the bigger story — food-noise at night drops, the evening pantry raid stops being a thing, and the restless late-night-snacking cycle that kept you up past midnight quietly ends. On the negative side, if you're eating dinner later than your new appetite wants, you may find reflux or a "too full" feeling making it harder to fall asleep. The fix: eat dinner earlier, eat less at dinner, and make sure protein is the anchor instead of carbs.

Reflux, meds, and sleeping position

Because GLP-1s slow gastric emptying, some people — especially in the first month — experience more reflux lying flat at night. In my experience, three things seem to help:

One, stop eating three hours before you lie down. Not two. Three. Your stomach is now running on a slower clock and it needs that extra time.

Two, sleep with your head and upper torso elevated — not just a second pillow, which can crimp your neck, but a wedge or an adjustable bed base. Gravity is free and it works.

Not medical advice. Always consult a licensed healthcare provider.

Three, if reflux is persistent beyond the first few weeks, talk to your doctor. This is a conversation, not a suffer-through. There are options.

A word about sleep trackers

Oura rings, Apple Watches, Fitbits, Whoop straps — these are all legitimate tools. But do not let the tracker become the boss of your sleep. The number that matters is how you feel when you wake up, not what a ring said about your REM percentage. Use the tracker to catch trends over weeks. Ignore the night-to-night noise. If the tracker is making you anxious about your sleep, that anxiety itself is hurting your sleep. Take it off for a week and see.

> ### Shep's sleep signals
>
> If you wake up hungry, your dinner was too early or too light on protein.
> If you wake up at 3 AM and can't get back — cortisol or alcohol. Check both.
> If you feel tired after seven hours — check hydration and iron.
> If you feel great after six hours — you're not actually getting six hours. Check the watch.

For shift workers and travelers

If your job moves your sleep around — nurses, pilots, parents of young kids, international travel — you are playing a harder game. The answer is not to quit the method. The answer is to protect the anchor variables: seven hours of total sleep in any twenty-four-hour window, daylight in the first hour of waking (whenever that is), and the last meal at least two to three hours before the longest sleep block.

One specific tactic for travelers: melatonin at a low dose (0.3 to 1 mg) timed to the new bedtime, not the old one, for the first three nights in a new time zone. Talk to your doctor. It is a nudge, not a sledgehammer — high-dose melatonin often makes the next day worse, not better.

Sleep and the people in your bed

You do not sleep alone, if you sleep with a partner. Their sleep affects yours, and yours affects theirs. A few things that came up in my own house and in honest conversations with friends on GLP-1.

Snoring. On GLP-1, weight loss often reduces snoring, which is a quiet win for the person next to you. If your partner has been sleeping in another room because of yours, this is a conversation worth having at month three. Test the bedroom together again.

Temperature arguments. Couples often disagree on bedroom temperature by three to five degrees. Layers and separate blankets solve it. This is not a compromise; this is a solution. Stop

Not medical advice. Always consult a licensed healthcare provider.

compromising on sleep.

Bedtime mismatch. If one of you is a night owl and the other a morning person, the one going to bed earlier should be able to get into bed at their time without the house lights and television running. Simple. Not always easy.

Morning light, specifically

Ten to fifteen minutes of outdoor daylight within the first hour of waking is one of the highest-return sleep interventions there is. Not through a window — outside. Your eyes need the spectrum and intensity of real sunlight to set your circadian clock, and the signal is much stronger than indoor light. Cloudy days still work.

If you cannot get outside — a winter morning, a shift-work schedule, a physical limitation — a bright light therapy lamp of 10,000 lux, used for twenty minutes near your face while you drink coffee, is a reasonable substitute. Not as good as sunlight. Still better than nothing.

Alcohol and sleep — the trade-off nobody wants to hear

Alcohol is a sedative. It will knock you out. It will also fragment your sleep in the second half of the night, reduce REM sleep, and leave you waking up between 3 and 5 AM with your heart racing. Every sleep researcher I've ever read on this topic lands in the same place: alcohol close to bedtime is bad for sleep, even if it feels good at the time.

On GLP-1, alcohol also tends to hit harder than before — smaller amounts feel like more. Combine that with the sleep fragmentation, and two glasses of wine with dinner on a Friday can cost you two bad nights. My rule: no alcohol within three hours of bed. Drinks with dinner at six, bed at ten — fine. Drinks until ten, bed at eleven — not fine.

The weekly sleep review

Every Sunday night, look back at the week. How many nights did you hit seven hours? Which nights didn't, and why? What one change are you making for the coming week? Write it down. Five minutes. Makes a real difference over months.

The chapter close

Sleep is the first letter because it is the only one of the five you cannot muscle through. You cannot out-discipline it. You cannot out-supplement it. You cannot out-protein it. You can only respect it.

Do this letter well, and the next four get easier. Ignore it, and the other four will feel heavier than they should.

Not medical advice. Always consult a licensed healthcare provider.

Chapter 6

H is for HYDRATION

The simplest rule in this book, and the one most GLP-1 patients get wrong in month one.

Not medical advice — work with your provider on anything that changes your protocol.

Not medical advice. Always consult a licensed healthcare provider.

Why hydration matters more on GLP-1

When you eat less food, you drink less water. That is not a character flaw — it is math. A lot of your daily hydration comes from food. Cut your food volume by a third, which is normal on GLP-1, and your water intake drops even if you never change your drinking habits.

At the same time, the medication can blunt thirst signals for some people. You are not as hungry, and you are not as thirsty. Meanwhile, your kidneys are still doing their job, your skin is still losing water, and your workouts — if you are doing the exercise letter right — are still sweating it out. The result, if you're not paying attention, is that Week 2 patients routinely walk around three or four glasses behind where they should be.

Dehydration on GLP-1 shows up as fatigue, headache, dizziness when you stand, constipation, and a strange low-grade "off" feeling. It is also the easiest thing in this entire book to fix.

The half-your-body-weight rule

There are many hydration formulas out there. The one I use, the one that is simple enough to actually remember, is this: drink half your body weight in ounces of water per day, as a floor.

If you weigh 200 pounds, that's 100 ounces a day — about three 32-ounce bottles. If you weigh 160 pounds, that's 80 ounces — about two and a half 32-ounce bottles. Round up when you exercise, round up in hot weather, round up when you fly.

Is this the perfect medical formula? No. Is it a target you can actually hit without an app and a spreadsheet? Yes. That is why we use it.

Electrolytes — when and why

Plain water is most of the answer. But when you are losing weight fast, sweating, or feeling off, electrolytes matter. Sodium, potassium, and magnesium are the three that most people running behind.

I use an electrolyte packet most mornings in the first three months of GLP-1 therapy, and on any day I train or travel. Pick a brand without a lot of added sugar — ideally under five grams per serving. Some are very salty; that is the point. Talk to your doctor if you have high blood pressure, kidney disease, or are on medications that affect potassium.

The morning coffee trap

Coffee is a diuretic. Not a massive one — habitual coffee drinkers adapt — but enough that replacing breakfast water with breakfast coffee is a net loss. The trap looks like this: you wake up, you're not hungry (thanks, GLP-1), you grab a coffee, you run your morning, and by ten AM you are behind on water and don't know it.

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Simple fix. Drink a full glass of water before your first coffee. Every day. No exceptions. It is the single highest-ROI habit in this chapter and it takes thirty seconds.

The hydration rule for this method

Half your body weight in ounces of water per day, floor.
One full glass of water before your first coffee. Every day.
Electrolytes in the first three months, on training days, and when traveling.
More when you sweat, fly, or feel "off."

1-Week Hydration Starter Plan

- ☐ Day 1 — Buy or pull out a 32-oz water bottle. Label it with target refills per day.
- ☐ Day 2 — Water glass before first coffee. Non-negotiable.
- ☐ Day 3 — Add an electrolyte packet to your first bottle of the day.
- ☐ Day 4 — Set two phone alarms: 11 AM and 3 PM. Top-up reminders.
- ☐ Day 5 — Track ounces for the day. Adjust the bottle schedule.
- ☐ Day 6 — Evening: stop liquids 90 minutes before bed. Protects sleep.
- ☐ Day 7 — Review. Which two reminders stay forever?

Recovery script — when you fall off

- ☐ Drink 20 oz of water with electrolytes within the next hour.
- ☐ Another 20 oz within the three hours after that.
- ☐ Back to your normal target tomorrow. Do not double up into tonight — sleep matters more.

The color check — a trick I learned in the first month

The simplest real-time hydration check nobody tells you about: the color of your urine. Pale yellow — like very weak lemonade — is where you want to be most of the day. Clear is a sign you're probably overdoing water at the expense of electrolytes. Dark yellow or amber means you are behind, right now, and should drink before you do anything else.

First thing in the morning is expected to be darker because you've been dehydrating overnight. The check that matters is mid-morning and mid-afternoon. If you're seeing dark all day, you are running a dehydration debt that is hurting your energy, your training, and your mood — and you do not know it.

Not medical advice. Always consult a licensed healthcare provider.

Why electrolytes, specifically, in month one

When you're losing weight fast — and especially if you're also eating lower-carb than before — your body excretes more sodium and water in the first few weeks. That's the "three pounds in a week" that looks like fat but isn't. The excretion is real, and so is the mineral loss that comes with it. Replacing it with a well-formulated electrolyte drink — one with meaningful sodium and potassium, not just flavoring — is what keeps your first month from feeling like a slog.

Ballpark numbers I aim for in the first month: 1,000 to 2,000 mg of sodium per day, 200 to 400 mg of potassium, 200 to 400 mg of magnesium. If you have high blood pressure, kidney disease, or any condition your doctor flags, check with them first — these numbers may be too high for you. This is not one-size-fits-all advice; it's a starting conversation.

Hydration and exercise

On training days, drink an extra 20 ounces of water with electrolytes in the hour before the session, and another 20 ounces in the two hours after. This is the single biggest "recovery" variable for most people on GLP-1, and it does not require a supplement drawer.

> *"The cheapest recovery tool in existence is a 32-ounce bottle and a pinch of salt."*
>
> — Shep

The sodium myth

Somewhere along the way American nutrition advice decided all sodium was bad for everyone. The truth is more nuanced. For most healthy adults, moderate sodium intake — especially when you are losing weight and sweating — is normal and necessary. Restricting it too aggressively causes lightheadedness, fatigue, cramps, and poor exercise performance. If you have blood pressure or heart conditions, follow your doctor's numbers. If you don't, stop fearing salt on your food in the first three months of a GLP-1.

What not to drink

Soda, even diet soda — not catastrophic, but won't help. Juice — liquid sugar, skip it. Energy drinks — look at the caffeine and the artificial sweetener load and ask whether you really need it. Alcohol — hits harder on GLP-1 than it did before. A lot of people find their tolerance drops noticeably. Respect that. The medication slows gastric emptying, and alcohol that sits in a slower stomach hits a different way.

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Shep's morning stack

Wake up. Bathroom. Weigh if it's weigh day.
One full glass of plain water (16 oz).
Electrolyte packet in the second glass.
Then coffee.
Total before breakfast: 32+ ounces of fluid, sodium and potassium on board.

A hydration schedule that actually works

Free-form "just drink more water" fails for most people. Structure wins. Here is the schedule I used in my first six months and still mostly use today.

- ☐ 6:30 AM — 16 oz plain water. No coffee yet.
- ☐ 7:00 AM — 16 oz water with an electrolyte packet. Then coffee is fine.
- ☐ 9:00 AM — another 16 oz during morning work.
- ☐ 11:00 AM — 16 oz before lunch.
- ☐ 1:00 PM — 16 oz with or after lunch.
- ☐ 3:00 PM — 16 oz afternoon top-up.
- ☐ 5:00 PM — 16 oz before dinner.
- ☐ 7:00 PM — 8 oz with dinner. Stop liquids by 8 PM to protect sleep.

That adds up to about 120 ounces. More than most people drink. Also more than most people think they can drink. The surprise is that once you hit the morning water + coffee routine for a week, the afternoons get easier, not harder — because you're not playing catch-up in a body that's quietly dehydrated.

Water quality, briefly

Tap water in most US municipalities is safe and drinkable. If you like the taste of filtered water, use a pitcher filter or a faucet filter. If you have well water, test it. Do not spend a fortune on alkaline water, hydrogen water, or bottled "premium" waters — the research does not support a benefit over clean tap or filtered water.

Plastic matters a little. Glass or stainless steel bottles avoid the microplastic and chemical leaching questions. A good stainless bottle lasts years. Worth the money.

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Caffeine, revisited

Coffee is a diuretic but not a dehydrator at habitual doses — your body adapts. Two to three cups of coffee a day is fine for most adults and actually contributes to total hydration. The exception is energy drinks and pre-workouts with 300+ mg of caffeine per serving — those will dehydrate faster than your body can replace.

On GLP-1, caffeine tolerance can shift. Some people find their usual three coffees now makes them jittery. Scale down if you notice. It will normalize after a month or two.

The chapter close

Hydration will not make headlines. It will not be the thing you post about. It will quietly fix half your first-month fatigue, most of your first-month constipation, and almost all of your first-month headaches.

Get this letter right and the exercise letter — coming next — will feel easier than you expect.

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Chapter 7

E is for EXERCISE

Lift something heavy two to three times a week, walk every day, and protect the muscle the medication cannot protect for you.

Not medical advice — work with your provider on anything that changes your protocol.

I am fifty-nine. I started lifting again at fifty-eight. If I can, so can you!

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Over 50, your body does not recover the way it used to. Some weeks I feel great and I hit three sessions. Other weeks my knees, my back, my sleep, or my schedule tell me two is the right number — and two is still the minimum effective dose for muscle preservation. What I do NOT do is skip a week entirely. Two imperfect sessions always beat zero perfect ones. That is the whole rule.

Why exercise matters more on GLP-1 — and why Strength / Resistance training is non-negotiable

I want to be careful with my words in this chapter, because this is the letter people skip and it is also the letter that, if skipped, will make you regret your weight loss three years from now.

When you lose weight, any weight loss — diet, surgery, or medication — a portion of the weight you lose is muscle. That is biology. The question is how much. Without deliberate Strength / Resistance training and adequate protein, studies on weight loss in general suggest that

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somewhere between twenty and forty percent of the pounds you lose can come off as lean mass, not just fat. That is not a number you want. Lean mass is the thing that keeps your metabolism up, your joints stable, your balance good, your blood sugar behaving, and your day-to-day life strong. Losing fifty pounds but losing twenty pounds of muscle in the process is not a win. It is a demotion dressed up as a win.

GLP-1s do not prevent muscle loss. Protein helps. Strength / Resistance training is the only thing that really protects it. The combination — the two together — is what turns a GLP-1 weight loss into a healthy body composition change instead of a smaller version of an unhealthy body.

The minimum effective dose

You do not need to become a powerlifter. You do need to train your major muscle groups against resistance, two to three times a week, for thirty to forty-five minutes, with progressively challenging loads. That is the minimum. That is also, for most people, the maximum they need.

Two to three sessions a week. Full body each time or upper/lower split. Six to eight exercises. Three sets each. Last few reps should feel hard. This is not Instagram. This is insurance for your next twenty years.

Walking is the foundation

On top of that, walk. Every day. Seven thousand to ten thousand steps is a reasonable target — and unlike social-media wisdom, you can build up to it gradually. Walking is not the workout. Walking is the floor. It keeps your joints moving, your mood regulated, your insulin sensitivity up, and your digestion — which on GLP-1 is slower than it used to be — working.

Can you skip the resistance and just walk? No. Walking is cardiovascular and metabolic. It does not build or protect muscle in any meaningful way. Walking plus lifting is the answer. Walking alone is a partial answer that will hurt you down the line.

> *"Cardio burns calories today. Lifting protects the person you'll be in ten years."*
>
> — Shep

Shep's story — starting at zero at fifty-eight

At fifty-eight years old, I had not lifted weights seriously since college.

Thirty-five years in medical device sales meant years of eating drive-thru food in my car between appointments. Too exhausted at 5 or 6 PM to go to the gym, I would go home to relax in front of the TV and watch the news, or ESPN SportsCenter 2-3x.

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When I started my GLP-1 journey, my doctor warned me: "You need to start strength training now. If you don't, you'll lose 40% of your weight as lean muscle — and you'll end up skinny and weak."

I did not want to end up looking like Olive Oyl from the Popeye cartoon.

So I started working out two to three times a week. After six months, I had dropped over thirty pounds and felt strong. My resting heart rate had dropped into the sixties. My pants were starting to feel loose.

If I could do it at fifty-eight, starting from the couch, you can do it too.

> **The exercise rule for this method**
> Strength / Resistance training two to three times a week, non-negotiable.
> Six to eight exercises, three sets each, last reps challenging.
> Walk every day. Work up to seven to ten thousand steps.
> Cardio by preference — not as a replacement for lifting.

1-Week Exercise Starter Plan

Assumes you are cleared by your doctor. If you have any cardiac, orthopedic, or other conditions, the plan must be approved by your provider first.

- ☐ Day 1 — 20-minute walk. Any pace. Outside if possible.
- ☐ Day 2 — Resistance Day A: squats, rows, push-ups. 3 sets of 8-10. Add walking.
- ☐ Day 3 — 30-minute walk. That is it. Recovery day.
- ☐ Day 4 — Resistance Day B: deadlifts (dumbbell RDL), overhead press, planks. 3 sets.
- ☐ Day 5 — 30-minute walk. Add 10 minutes of mobility or stretching.
- ☐ Day 6 — Resistance Day C: goblet squats, rows, carries. 3 sets.
- ☐ Day 7 — Long easy walk. 45 minutes. Review the week in your head.

Recovery script — when you fall off

- ☐ Today: one walk. Any length. Just move.
- ☐ Tomorrow: one Strength / Resistance session, even if short. 20 minutes counts.
- ☐ No guilt, no doubling up. Return to your two-to-three-times-a-week rhythm this week.

Not medical advice. Always consult a licensed healthcare provider.

Why I say "non-negotiable" about Strength / Resistance training

Language is a choice. I chose "non-negotiable" deliberately. I didn't say "recommended." I didn't say "strongly encouraged." I said non-negotiable because — in every conversation I've had with physicians about GLP-1 outcomes, and in everything I have read from the researchers studying these medications — the single biggest difference between people who kept their results and people who didn't was Strength / Resistance training. Not cardio. Not yoga. Not walking alone. The presence of a real, progressive load on the major muscle groups, two to three times a week, for the duration of the weight-loss journey and beyond.

If you are going to skip this chapter, close the book. I mean that with love. The method does not work without it. Everything else is easier to skim. This one is load-bearing — literally.

The six movements that cover 80% of the benefit

You do not need a hundred exercises. You need six patterns, done well, progressed over months. Here they are.

- ☐ Squat pattern — goblet squats, box squats, or dumbbell squats later.
- ☐ Hinge pattern — Romanian deadlifts, kettlebell swings, or conventional deadlifts.
- ☐ Horizontal push — push-ups, bench press, dumbbell chest press.
- ☐ Horizontal pull — bent-over rows, seated cable rows, inverted rows.
- ☐ Vertical push — overhead press, dumbbell shoulder press.
- ☐ Vertical pull — pull-ups (assisted if needed), lat pulldowns.

Add a core movement (planks, dead bugs) and a carry (farmer carries, suitcase carries) and you have the complete kit. Three working sets per movement, last rep challenging, rest ninety seconds between sets. Thirty to forty-five minutes per session. Two to three sessions a week. That is the program.

Progressive overload, explained simply

The rule your body requires: give it a reason to keep the muscle you're training it to hold. That reason is a gradual, consistent increase in the work it has to do. Small increases. Not big ones. Not every session — that's how you get injured. Small increases, over weeks and months.

Rep-based progression: when you can do all three sets at the top of the target range with good form, add weight and drop back to the bottom of the range. Rest-based progression: when workouts feel easier, shorten rests by ten seconds. Range-based progression: deeper squats, fuller rows, better technique.

Write down what you did every workout. It does not need to be a fancy app. A notebook in your gym bag works. Seeing the numbers climb over months is one of the most motivating things in

Not medical advice. Always consult a licensed healthcare provider.

this method.

> **What to do if you can't get to a gym**
> Bodyweight — push-ups, squats, lunges, pull-ups on a doorway bar. Not a joke.
> Resistance bands — cheap, travel-friendly, genuinely effective.
> Adjustable dumbbells — one investment, one corner of the house, ten years of use.
> Kettlebells — start light at first. Good form is more important than heavy weight.

Walking — how much, and how it fits

Walking is not optional either. It is just secondary to resistance. Ten thousand steps is a nice round number. It is also arbitrary. The research suggests most of the benefit of daily walking shows up by about seven thousand steps, with diminishing returns beyond that. Aim for seven. Hit ten when you can. Do not turn it into a guilt number.

Break it up. Ten minutes after each meal is better than a single thirty-minute block because of what it does to post-meal blood sugar. A morning walk in daylight anchors your circadian rhythm, which helps your sleep, which makes everything else easier. All these habits loop back into each other — that is the point of the Method.

What about cardio — running, cycling, swimming

All great. All fine. All not a substitute for lifting. If you love your cycling group or your morning run, keep them. Add the Strength / Resistance training alongside — not in place of — the cardio you enjoy. Two to three thirty-minute strength sessions a week coexist with almost any cardio schedule without burning you out.

> *"Strength / Strength / Resistance work is required. Cardio is extra credit."*
> — Shep

The first Strength / Resistance session — exactly what to do

If you have never lifted a weight or haven't in twenty years, here is your first session. Do not overthink it.

Warm-up (5 minutes): march in place, arm circles, bodyweight squats to depth, push against a wall with arms straight. Get blood moving.

Workout A, 30 minutes:

- ☐ Goblet squats — hold a dumbbell at chest, squat to parallel. 3 sets of 8.

Not medical advice. Always consult a licensed healthcare provider.

- ☐ Dumbbell rows (one arm on a bench) — 3 sets of 8 per side.
- ☐ Push-ups from the floor or from a counter — 3 sets of 5 to 10.
- ☐ Dumbbell overhead press — 3 sets of 8.
- ☐ Plank — 3 sets of 20 to 30 seconds.

Cool down (2 minutes): walk, stretch, breathe. Done. That's your first session. Write down the weights. Next session in three days.

Soreness and when to worry

Muscle soreness 24 to 48 hours after a new workout is normal. It is called delayed-onset muscle soreness — DOMS — and it is not injury. It gets better the more consistently you train, not worse.

Pain in a joint — knee, shoulder, lower back, wrist — during or after a lift is different. That is a "stop the exercise and examine it" signal. Common causes: form issues, going too heavy too fast, skipping a warm-up. Less common but real: actual injury. If pain lasts more than a week or is sharp, see a physical therapist or sports medicine doctor. Do not power through it.

A word about personal trainers

If you can afford a few sessions with a qualified personal trainer early, do it. Not forever — just enough to learn the movements with good form. The investment in technique at the beginning prevents a decade of bad habits and injuries down the line. Look for trainers with NSCA, ACSM, or NASM certification, and ideally experience with older adults or rehabilitation.

If you cannot afford a trainer, there are excellent free resources. Jeff Nippard, Renaissance Periodization, and Starting Strength on YouTube have well-produced, evidence-based tutorials on every movement in this chapter. Watch two videos of any movement before you attempt it.

One more YouTube recommendation, from me personally: Bobby Maximus. He has a deep library of Strength / Resistance training videos designed for people over 40, and I have incorporated a lot of his basic exercises into my own workouts. His content is practical, age-appropriate, easy to understand, and safe for beginners.

If you want to really dig deep, you can always pick up what I consider the gold standard for Strength / Resistance training: The New Encyclopedia of Modern Bodybuilding by Arnold Schwarzenegger. At 800+ pages, it covers every movement, muscle group, and training protocol with photos and detailed form notes. It has been on my bookshelf since I started lifting again. Click here to find it on Amazon.

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The 12-week arc

Your first twelve weeks of Strength / Resistance training is the most important stretch of the entire method. Twelve weeks — 24 to 36 sessions depending on your cadence — is enough to go from "I've never done this" to "this is part of my life now." That is what you are building in this chapter. Not a physique. A habit.

12-week progression, in one box

Weeks 1 to 4 — learn the six movements. Light weights. Focus: form.
Weeks 5 to 8 — add weight each week if the last set was easy.
Weeks 9 to 12 — test your working weights. Set benchmarks. Photograph them.
End of week 12 — you are a person who lifts. That identity is durable.

The chapter close

If you do only one thing from this entire book, do the lifting. I mean that. Not because it will make you look a certain way, but because it is the single most underrated protective habit on GLP-1, and it is the habit that most patients skip.

Lift something heavy two to three times a week. Walk every day. Your future self will not be subtle about how grateful it is.

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WHAT'S NEXT

Want the rest?

The full Book 1 — Your First 9 Months on GLP-1 — includes:

- Chapter 8 — PROTEIN (the exact calorie- and gram-level protocol with worked examples)
- Chapter 9 — SUPPLEMENTS (the six-bottle short list plus labs to request)
- Your First 90 Days — weeks 1-4, month 2's plateau-that-isn't, month 3 doctor conversations, the first regression, and what to track
- Closing — Where I Am Today — 9 Months In (April, 2026): Shep's honest status report and a preview of Book 2
- The printable back-matter toolkit — Daily Checklist, First Appointment Checklist, 10 Questions to Ask Your Provider, and the Resources page

Get the full version for $29

Or visit glp1maps.com/book

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PREVIEW — CHAPTER 8

A peek at P is for PROTEIN

In the full book, Chapter 8 is the calorie- and gram-level protocol that takes the single biggest variable in a GLP-1 weight loss — protein — and turns it into a habit you can actually execute. Here's the rule and the worked example. Everything else — the refrigerator reset, animal and plant sources, shakes, the realistic day of eating at two body weights — is in the full version.

> **The protein rule**
> 0.8 to 1.2 grams of protein per pound of target body weight, with roughly 30 g per meal.
>
> Target body weight = the weight you are working toward, not the weight you are today.

Worked example

Say your goal weight is 180 pounds. The rule gives you a range: 0.8 × 180 = 144 g/day minimum. 1.2 × 180 = 216 g/day max. Spread across three meals plus one snack, that's roughly 30 to 60 grams at each meal, plus a protein-rich snack. Most patients land in the middle — around 160 to 180 grams per day — and get there by anchoring every meal with a protein source first, and building the rest of the plate around it.

If your goal weight is 150: 120 to 180 g/day. If 200: 160 to 240 g/day. Simple math. The habit of hitting it is what takes the first few weeks to build.

> *"On GLP-1, you have a smaller plate in the same kitchen. Put the protein on it first."*
>
> — Shep

This is a preview. The full chapter — including the refrigerator reset, the animal/plant source tables, shakes, timing, and a 1-week starter plan — is in the full 85-page book.

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PREVIEW — CHAPTER 9

A peek at S is for SUPPLEMENTS

The last letter of the Method, and the one most people overthink. Chapter 9 in the full book covers the short list of supplements that actually matter on GLP-1, the labs to request, the order of operations, and Shep's own stack at year three. Here's the short list.

The supplements short list

Multivitamin daily, with food.
Magnesium glycinate 200 to 400 mg in the evening.
Psyllium fiber once a day with a full glass of water.
B12, Vitamin D3, and Omega-3 as labs and doctor direct.
Nothing in this list is a substitute for healthy food.

Labs to ask for

At minimum, at baseline and then at least yearly: Comprehensive Metabolic Panel (CMP), Lipid panel, A1c, Vitamin D (25-OH), Vitamin B12, iron panel / ferritin (especially for women), and a thyroid panel (TSH, Free T4). The full chapter goes deeper on DEXA, bone density, and year-three labs worth asking about.

> *"Food is the stack. Supplements cover the gaps food doesn't fill."*
>
> — Shep

The full chapter — including storage, third-party testing, the annual audit, and the full 1-week starter plan — is in the full version of the book.

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PREVIEW — PART III

A peek at Your First 90 Days

Part III of the full book walks you through the first three months on GLP-1 — week by week, month by month — so you know what to expect, what to ignore, and how to come back when you wobble. Five chapters. Here are the headlines.

What's inside

- Weeks 1-4: The Adjustment. Side-effect management, the micro-wins to track, the daily scale trap, and what to ignore.
- Month 2: The Plateau That Isn't. Why the scale stalls in weeks 5-8, body composition versus body weight, and when to actually worry.
- Month 3: Dose Changes + Doctor Conversations. How to prepare for titration discussions, what to track beyond weight, and the questions that get real answers.
- The First Regression. The vacation, the wedding, the bad weekend — and the 48-hour reset protocol that brings you back to baseline without drama.
- What to Track (and What to Ignore). Five metrics, three cadences, a simple monthly review, and the confidence to ignore everything else.

> *"The first month is not the month you'll remember. It's the month that earns you every month after."*
>
> — Shep

Full Part III is in the complete version of the book.

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PREVIEW — CLOSING

Where I Am Today — 9 Months In

April, 2026

Book 1 closes the way it opened — honest. Nine months and eight days in. Fifty pounds off. A gym Shep joined at fifty-eight. A real two-week beach vacation that put seven pounds back on and a five-habit system that took them back off in two weeks. No three-year victory lap — because Shep is not three years in. He is nine months in, and that is exactly the story this book tells.

What's in Book 1's closing note

- The honest status report. What changed in nine months — weight, sleep, resting heart rate, how clothes fit, how the gym feels.
- What Book 1 is, and what it is not. Why Shep chose to write the nine months he has lived instead of a year he hasn't.
- A preview of Book 2. The one-year labs, the maintenance conversation, what happens when the weight stabilizes — coming at month eighteen.
- A direct word to you. Whether you are three weeks in or three months in, the Method is the same. Five things. Every day.

> *"The Method works — if you do the five steps every day."*
>
> — Shep

The full closing note is in the complete version of Book 1.

Not medical advice. Always consult a licensed healthcare provider.

The S.H.E.P.S. Method — At a Glance

The five daily rules. One page. Screenshot it, print it, tape it inside your medicine cabinet.

S — The sleep rule

Seven hours minimum in bed, eyes closed. Target eight.
Cool, dark room. Phone outside the bedroom or face-down across it.
No caffeine after two PM.
Magnesium glycinate in the evening, with your doctor's OK.

H — The hydration rule

Half your body weight in ounces of water per day, floor.
One full glass of water before your first coffee. Every day.
Electrolytes in the first three months, on training days, and when traveling.
More when you sweat, fly, or feel "off."

E — The exercise rule

Strength / Resistance training two to three times a week, non-negotiable.
Six to eight exercises, three sets each, last reps challenging.
Walk every day. Work up to seven to ten thousand steps.
Cardio by preference — not as a replacement for lifting.

P — The protein rule

0.8 to 1.2 grams of protein per pound of target body weight, with roughly 30 g per meal.

Target body weight = the weight you are working toward, not the weight you are today.

S — The supplements rule

Multivitamin daily, with food.
Magnesium glycinate 200 to 400 mg in the evening.
Psyllium fiber once a day with a full glass of water.
B12, Vitamin D3, and Omega-3 as labs and doctor direct.
Nothing in this list is a substitute for healthy food.

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PREVIEW — FULL TABLE OF CONTENTS

Everything in the full 85-page book

Not medical advice. Always consult a licensed healthcare provider.

Resources

Glossary, Acknowledgments, About the Author

Not medical advice. Always consult a licensed healthcare provider.

PREVIEW — PRINTABLE TOOLKIT

A peek at the Daily Checklist

The full 85-page book includes a printable version of this checklist. Here's a preview so you can see the format. Laminate it, tape it to the fridge, check it every night.

- ☐ **SLEEP** Seven hours minimum, eyes closed. Cool, dark, no phone in bed.
- ☐ **HYDRATION** Half your body weight in ounces of water. Glass before first coffee.
- ☐ **EXERCISE** Strength / Resistance training 2-3× week. Walk every day (target 7-10k steps).
- ☐ **PROTEIN** 0.8 to 1.2 grams per pound of target body weight (~30 g/meal).
- ☐ **SUPPLEMENTS** Multivitamin, magnesium glycinate, fiber, B12, D3, Omega-3 (consult your provider).
- ☐ **TRACK** Weight weekly, waist every 2 weeks, energy daily, one monthly review.
- ☐ **RECOVERY** Fell off? Run the 48-hour reset. Back to baseline. Keep going.

> **The protein rule in this book**
> 0.8 to 1.2 grams of protein per pound of target body weight (~30 g/meal).
> Target body weight = the weight you are working toward, not the weight you are today.

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PREVIEW — YOUR APPOINTMENT

10 Questions to Ask Your Provider

In the full book, this appears as a tear-out page you can take to your appointment. Here are the questions.

1. Which GLP-1 do you think is best for me, and why that one?
2. What is the starting dose, and what is the target dose we're aiming for?
3. What is the titration schedule — how often do we step up?
4. What side effects should I expect, and what should make me call you?
5. What baseline labs do you want before I start?
6. How often will we check labs once I'm on the medication?
7. What are your expectations for my weight loss over 3, 6, and 12 months?
8. How should I think about exercise and protein alongside the medication?
9. What's the long-term plan — maintenance dose, or taper at goal?
10. How will we handle a plateau, a regression, or a side-effect flare?

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GLOSSARY

Glossary

The short list of terms you'll hear in the GLP-1 era.

A1c — A blood test showing average blood glucose over the prior 2-3 months.

BMI — Body Mass Index. A rough ratio of weight to height. Imperfect but widely used.

CMP — Comprehensive Metabolic Panel. Covers kidneys, liver, electrolytes.

DEXA — Dual-energy X-ray absorptiometry. Gold-standard body composition + bone density.

DOMS — Delayed-onset muscle soreness. Normal after new Strength / Resistance training.

Ghrelin — Hunger hormone. Rises before meals, falls after.

GLP-1 — Glucagon-like peptide-1. Natural hormone and the target of these medications.

GIP — Glucose-dependent insulinotropic polypeptide. A second target in tirzepatide.

Leptin — Fullness hormone. From fat cells. Chronic excess weight blunts its signal.

Liraglutide — Older daily-injected GLP-1 agonist. Brand: Saxenda (weight) / Victoza (diabetes).

Maintenance dose — A stable dose to hold results, typically lower than the peak dose.

Semaglutide — The molecule in Ozempic, Wegovy, and Rybelsus.

Set point — The weight your hypothalamus defends. Hard to move with diet alone.

Sodium — Key electrolyte. Often needs deliberate replacement on GLP-1.

Titration — Stepwise dose increase designed to minimize side effects.

Tirzepatide — The molecule in Mounjaro and Zepbound. Dual GLP-1/GIP agonist.

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ACKNOWLEDGMENTS

Thank You

To Kate, my wife, who watched this experiment begin and backed every odd habit it's produced — thank you.

To the physicians who sat across desks and coffee tables and pharmacy counters with me over thirty-five years and patiently translated their expertise into language a sales rep could carry to the next clinic: you taught me how to listen. This book is your handwriting.

To my own provider, who supported me and answered all of my questions. These first nine months on GLP-1 have had good days and bad days, but you encouraged me that my body would adjust to the medication. And you were right.

To the readers who have followed my writing at TheGLP1Guide.net and who use GLP1Maps.com — you are the reason this book is not theory. The questions, the notes of encouragement, the honest pushback have all shaped the method on the page. Keep writing me. Keep correcting me. Keep going.

To the manufacturers and researchers who brought these molecules to market across decades of science — I have my criticisms of the pricing and the access, but I am unambiguously grateful for what you built. Millions of lives are going to be different because of your work.

And to the reader: you are the reason any of this exists. Go well.

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ABOUT THE AUTHOR

About Mark “Shep” Shepherd

Mark "Shep" Shepherd spent thirty-five years in medical device sales — thirty of them selling to ENT doctors, and the last twenty-six with Medtronic, the largest medical device company in the world. He was twice named U.S. Rep of the Year while covering Northern California and spent most of his career in operating rooms alongside surgeons and nurses in small community hospitals and large teaching hospitals.

He retired in May of 2024 at fifty-seven. A year later, after the weight would not budge and the labs would not improve, he sat down with his doctor and started a GLP-1. Over the next nine months — on the medication plus a five-habit system he developed for himself — he lost fifty pounds. That system is now The S.H.E.P.S. Method.

Your First 9 Months on GLP-1 is Book 1 of The S.H.E.P.S. Method Series. Book 2 will follow at month eighteen.

He is retired. Married to his wife Kate, and has a five-year-old daughter, Alison. This is his first book.

If you would like to drop him a note, feel free at Mark@ShepsMethod.com.

April, 2026

Mark "Shep" Shepherd
Founder, The GLP-1 Guide and The S.H.E.P.S. Method
GLP1Maps.com · TheGLP1Guide.net · ShepsMethod.com

“This is not a phone book. This is a Healthy Lifestyle Support System.”

Not medical advice. Always consult a licensed healthcare provider.

RESOURCES

Resources

GLP-1 Maps
The most comprehensive GLP-1 focused provider directory in the U.S. with over 11,800 providers in all 50 states.
glp1maps.com

The GLP-1 Guide
Shep's ongoing writing, updates, and reader resources.
TheGLP1Guide.net

First GLP-1 Appointment Checklist
Standalone printable version of the appointment prep in this book.
glp1maps.com/downloads/First_GLP1_Appointment_Checklist.pdf

Shep's Daily Checklist
Standalone daily printable — laminate it, tape it, use it.
glp1maps.com/downloads/SHEPS_Daily_Checklist.pdf

Shep's Bookshelf
Recommended reading, printable checklists, and adjacent resources.
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Shep's Method Website
The book's home page. Buy Book 1, read the excerpt, join the list.
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This is not a phone book. This is a Healthy Lifestyle Support System.

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One more time:

Sleep.
Hydration.
Exercise.
Protein.
Supplements.

This is not a phone book.
This is a Healthy Lifestyle Support System.

— Mark "Shep" Shepherd

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Ready for the full 85 pages?

Your first 90 days. The closing 9-month note. The full toolkit.

Before

After

The full Book 1 includes Chapter 8 Protein (with the exact gram-level protocol), Chapter 9 Supplements, Your First 90 Days, the closing 9-month note (Where I Am Today), and the printable back-matter toolkit.

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