

PROJECT / REBUILD

PHASE 1 / NUTRITION + ADHERENCE

THE HUNGER SWITCH

Turn Down Hunger. Build Habits That Hold.

A practical 14-day nutrition and lifestyle system for adults using prescribed GLP-1 or related medication for weight management.

KEVIN REESE

PROJECT REBUILD

READ THIS FIRST

This is a system, not a treatment plan

The Hunger Switch helps you organize food, habits, and decisions around treatment you already receive from a licensed clinician.

SCOPE

This guide does not diagnose, prescribe, choose a medication, change a dose, manage diabetes medication, or replace your prescriber or a registered dietitian. Personal experience is labeled. General guidance is not individualized care.

Use your clinician for the medical decisions

- Take medication exactly as prescribed. Do not change dose, timing, or combinations because of this guide.
- Ask for individualized nutrition advice if you are pregnant or breastfeeding, under 18, have kidney or liver disease, diabetes treated with insulin or a sulfonylurea, a history of an eating disorder, significant frailty, or another condition that changes nutrition needs.
- Tell every procedural or anesthesia team that you use a GLP-1 medication. Follow their current fasting and medication instructions.

Do not troubleshoot serious symptoms with a PDF

Seek prompt medical guidance for symptoms that are severe, persistent, worsening, or preventing fluids or basic nutrition. Get urgent help for trouble breathing, swelling of the face/lips/tongue/throat, fainting, or severe abdominal pain that does not go away.

Medication-specific warnings differ; read your current Medication Guide.

Safety language is aligned with current FDA prescribing information for Wegovy and Zepbound. See Sources [2]-[3].

THE OUTCOME

What you should be able to do in 14 days

Not memorize a diet. Build a repeatable way to make the next good decision—even when appetite, schedule, and the scale are unpredictable.

By Day 14, you can...	What that looks like
Protect nutrition	Use a clinician-approved protein target and a priority order when volume is limited.
Build a meal	Combine a protein anchor, produce, an optional smart carbohydrate, and flavor/fat.
Adapt to appetite	Switch among full meals, small meals, and mini-feedings without abandoning structure.
Handle real life	Choose workable restaurant, convenience, family, and no-cook options.
Read progress	Use trends, behaviors, waist/fit, energy, and strength—not one scale reading.
Recover quickly	Return at the next meal instead of punishing an imperfect day.

THE PROMISE

The system is designed to create clarity and repeatability. It does not promise a particular amount or rate of weight loss.

A NOTE FROM KEVIN

Why I built The Hunger Switch

The medication can make eating less easier. That does not automatically make eating well easier.

My own experience using GLP-1 medications has taught me how wide that gap can be. Hunger can get quieter while the practical questions get louder: What do I eat first? How do I get enough protein when I fill up fast? Am I losing fat or just getting lighter? What happens when the scale stalls or hunger returns?

I have had meaningful success, but I do not believe my experience is a universal formula. This system separates three things on purpose:

- **Personal experience:** what I noticed, what made adherence easier, and what I wish I had treated as important sooner.
- **General principles:** meal structure, protein planning, food quality, hydration, sleep, movement, and consistency.
- **Clinical decisions:** medication, side effects, individualized targets, medical conditions, lab monitoring, and treatment changes.

WHAT I WISH I KNEW

Appetite relief is an opportunity—not a finished plan. The goal is to use the quieter hunger to build a system you can still recognize later.

THE CORE IDEA

Medication lowers the noise. You choose what fills the space.

A GLP-1 can change appetite, fullness, food interest, and intake. It cannot plan Tuesday dinner or protect your routines by itself.

The old loop

Strong hunger -> reactive choice -> oversized portion -> guilt -> overcorrection -> strong hunger again.

The new loop

1. **Pause.** Notice appetite, symptoms, schedule, and what is realistically available.
2. **Prioritize.** Get the highest-value nutrition into the smallest comfortable amount of food.
3. **Build.** Use the same meal formula instead of inventing a diet every day.
4. **Review.** Judge trends and behaviors, then change one variable when needed.
5. **Repeat.** Return quickly after imperfect meals. Repetition is the product.

THE HUNGER SWITCH RULE

Do not use appetite suppression to see how little you can survive on. Use it to make enough good decisions with less friction.

THE RIGHT SCOREBOARD

Weight loss, fat loss, and muscle loss are not the same

The scale reports total mass. It cannot tell you which tissue changed or whether your daily function improved.

Term	What it means	Why it matters
Weight loss	A decrease in total scale weight.	Can include fat, water, glycogen, gut contents, and lean tissue.
Fat loss	A decrease in stored body fat.	Usually the central body-composition goal.
Lean mass	Everything that is not fat; includes muscle and water.	Some lean-mass change is not pure muscle change.
Muscle preservation	Keeping as much functional muscle as practical during loss.	Supports strength, mobility, function, and long-term rebuilding.
Body composition	The relationship among fat, lean tissue, and total mass.	A slower scale change can still accompany better fit, waist, or strength.

Track more than one signal

- Four-week weight trend
- Waist measurement monthly
- Clothing fit
- Energy and daily function
- A few repeatable strength markers once medically appropriate

Muscle preservation through adequate nutrition plus resistance training is a central priority in the 2025 joint GLP-1 nutrition advisory. See Source [1].

THE PRIORITY LADDER

When appetite is low, order matters

You may not finish everything. Start with what is hardest to replace and stop before discomfort.

Priority	Decision
1 / Safety	Are you unable to keep fluids down, or are symptoms severe, persistent, or worsening? If yes, leave the guide and contact the appropriate clinician.
2 / Fluids	Sip regularly. Use the hydration plan your clinician approves; needs vary with health, climate, and losses.
3 / Protein	Eat the protein anchor first or use a smaller, easier form.
4 / Plants + fiber	Add tolerated fruit, vegetables, beans, or whole grains; increase gradually when needed.
5 / Energy + variety	Add carbohydrate and fats in amounts that support energy, satisfaction, and nutritional adequacy.
6 / Optimization	Fine-tune timing, recipes, and tracking only after the basics work.

BUILD THE BASICS FIRST

Optimizing calories can miss the basics: enough protein and fluids, food variety, and a repeatable plan.

PROTEIN

Choose a working target without pretending there is one perfect formula

Protein matters during weight loss, but larger body weight can make body-weight formulas wildly overestimate needs.

The 2025 joint advisory notes that there is no consensus on whether protein targets for people with obesity should use actual weight, adjusted/ideal weight, or fat-free mass. It offers 80-120 grams per day as one practical absolute range, while recognizing that individual needs vary.

Use one of these routes

1. **Clinician target (best when available).** Use the number provided by your prescriber or registered dietitian.
2. **Working discussion range.** Bring 80-120 g/day to your clinician and choose a starting point based on body size, age, activity, tolerance, medical conditions, and total intake.
3. **Meal-anchor route.** Plan three protein anchors of roughly 25-35 g each, then add a 15-25 g booster if your approved target requires it.

IMPORTANT

Kidney disease, liver disease, pregnancy, frailty, certain metabolic conditions, and other medical situations can change protein needs. A calculator cannot screen you.

See Source [1], especially the advisory discussion of protein during active weight reduction.

PROTEIN PLANNING

Turn a daily target into food you can finish

Distribute the work. One heroic dinner is harder than two or three planned anchors.

Eating rhythm	Anchor plan	Illustrative total
3 meals	25-35 g + 25-35 g + 25-35 g	75-105 g
2 meals + booster	35-45 g + 35-45 g + 15-25 g	85-115 g
4 mini-feedings	20-30 g each	80-120 g
Low-appetite day	15-25 g x 4, as tolerated	60-100 g; flag repeated shortfalls

Approximate protein anchors

Food	Practical portion	Approx. protein*
Chicken or lean beef	4 oz cooked	~28-32 g
Fish	4 oz cooked	~22-28 g
Greek yogurt	1 cup	~18-25 g
Cottage cheese	1 cup	~24-28 g
Eggs + egg whites	2 eggs + 1/2 cup whites	~25 g
Tofu	6 oz firm	~18-24 g
Protein beverage	1 serving	~20-30 g

**Brands, cuts, and preparation vary. Use labels when precision matters.*

LOW-VOLUME NUTRITION

When you can only eat a little

Reduce volume before you reduce nutritional priority.

Use the small-volume sequence

1. **Shrink the serving.** Put half the usual amount on the plate. More is available if comfortable.
2. **Lead with the anchor.** Start with protein; do not fill up on a large drink or salad first.
3. **Choose softer options.** Yogurt, cottage cheese, eggs, fish, tofu, soup, or a tolerated smoothie may feel easier than dense meat.
4. **Separate fluids if needed.** Sip between eating times if drinking with meals makes fullness worse.
5. **Add another opportunity.** Two bites now and another planned mini-meal later can beat forcing one large plate.

PATTERN TO FLAG

One unusually light day may happen. Repeated inability to meet basic fluid or nutrition needs, worsening weakness/dizziness, or persistent symptoms belongs with your clinician—not a stricter diet.

PRACTICAL LESSON

The useful question is not “How little can I eat?” It is “What is the best next bite I can comfortably tolerate?”

THE MEAL BUILDER

One formula, hundreds of workable meals

Build around protein plus produce plus optional carbohydrate, with flexible portions for changing appetite and real life.

Layer	Choose one	Purpose
1 / Protein anchor	Poultry, fish, lean beef, eggs, Greek yogurt, cottage cheese, tofu, beans/lentils, approved fortified option	Makes protein visible and planned.
2 / Produce	Cooked or raw vegetables; fruit; soup-based vegetables	Adds fiber, micronutrients, color, and variety.
3 / Smart carbohydrate	Potato, rice, oats, beans, corn, fruit, whole-grain bread/tortilla	Supports energy, training, satisfaction, and flexibility.
4 / Flavor + fat	Olive oil, avocado, nuts, cheese, sauce, seasoning	Makes the meal worth repeating; use lighter amounts if high fat worsens symptoms.

Three examples

- Salmon + roasted green beans + small potato + lemon.
- Greek yogurt + berries + oats + chopped walnuts.
- Chicken burrito bowl: chicken + peppers + rice/beans + salsa; stop at comfortable fullness.

CARBS ARE OPTIONAL AT A MEAL—NOT FORBIDDEN

Use appetite, total intake, activity, glucose plan, and tolerance. Carbohydrate timing is a preference tool, not a universal fat-loss rule.

EATING RHYTHMS

Choose the pattern your appetite can repeat

There is no prize for eating a particular number of meals. There is value in planned opportunities that make adequate nutrition easier.

Pattern	Use it when...	Watch for...
3 anchors	You tolerate breakfast/lunch/dinner and prefer routine.	Tiny protein portions at each meal that never add up.
2 meals + booster	You naturally eat later or prefer larger meals.	Waiting so long that nausea, weakness, or an evening binge follows.
4 mini-feedings	Early fullness makes standard meals difficult.	Grazing without a plan; write the four anchors down.
Flexible family dinner	You need the same dinner as the household.	Build your plate from shared components; do not cook a separate "diet meal."

Breakfast is not a moral issue

Delaying the first meal is optional, not a rule. If you are not hungry and can still meet your needs comfortably, a later first meal can work. If long gaps worsen nausea, fatigue, overeating, or nutrition shortfalls, eat earlier and/or smaller.

PORTIONS + CALORIES

Create a deficit without making deprivation the identity

Fat loss requires lower energy intake over time. The medication often helps create that gap. Your job is not to make the gap as large as possible.

Use the comfort-first plate

- **Start small.** Serve a comfortable portion. You can add more.
- **Protein first.** Protect the anchor before appetite disappears.
- **Add plants as tolerated.** Cooked options can be easier than bulky raw foods.
- **Add energy intentionally.** Carbs and fats are tools, not failures.
- **Stop at comfortable satisfaction.** Do not force fullness to “clean the plate.”

If you track calories

Use a target set with your clinician or dietitian. Treat it as a planning range, not a contest to stay underneath. If appetite suppression repeatedly pulls you far below the plan, that is information to share—not proof the medication is working better.

WHEN LESS FOOD IS NOT AUTOMATICALLY BETTER

A lower scale number is not a win if it comes with repeated dehydration, inadequate protein, worsening weakness, loss of function, or a pattern you cannot sustain.

FLUIDS + FIBER

Support the system without creating another rigid rule

GLP-1 therapy can make thirst, fullness, nausea, diarrhea, and constipation more important to monitor.

Build a hydration rhythm

- Use the fluid target your clinician recommends. Needs vary with body size, climate, activity, heart/kidney conditions, and fluid losses.
- Attach sips to routines: wake-up, commute, meal prep, medication time, and afternoon transition.
- Watch for dark urine, dry mouth, headache, dizziness, or falling intake; symptoms can have many causes, so report concerning or persistent changes.

Increase fiber like a dimmer, not a switch

- Start with tolerated foods: berries, kiwi, cooked vegetables, beans/lentils, oats, potatoes with skin, or whole grains.
- Increase gradually and pair with adequate fluids. A sudden jump can increase gas or discomfort.
- If high-volume raw produce is hard to tolerate, use cooked, peeled, blended, or smaller portions.

The joint advisory supports adequate fluids and gradual food-based fiber strategies for constipation. See Source [1].

LOW APPETITE + NAUSEA

A practical response—not a medication adjustment

This page helps with food decisions around mild symptoms. It does not diagnose the cause or tell you how to change treatment.

Try	Why it may help
Smaller, more frequent eating opportunities	Can reduce the burden of a standard-size meal.
Lower-fat, simply prepared foods temporarily	Large or high-fat meals can worsen fullness or nausea for some people.
Cool or room-temperature foods	They may have less aroma and feel easier when food aversion is high.
Soft protein options	Yogurt, cottage cheese, eggs, fish, tofu, or soup can reduce chewing/volume burden.
Slow eating; stop early	Vomiting is more likely after large meals; do not push past discomfort.
Regular sips between meals	Supports hydration when drinking a lot with meals worsens fullness.

CALL YOUR CLINICIAN

Persistent nausea/vomiting/diarrhea, inability to keep fluids down, severe or persistent stomach symptoms, or signs of dehydration require medical guidance. Follow your medication's current label.

See Sources [1]-[3].

CONSTIPATION + GI CHANGES

Start gently; escalate appropriately

Constipation is common, but severe, prolonged, or painful symptoms should not be normalized.

1. **Review fluids.** Low intake can make constipation harder.
2. **Increase food-based fiber gradually.** Use tolerated fruit, vegetables, oats, beans, or whole grains.
3. **Add gentle movement if appropriate.** A short walk can support routine and is easier to repeat than punishment exercise.
4. **Notice the pattern.** Record bowel movements, pain, vomiting, fluid intake, and duration so your clinician gets useful information.
5. **Ask before adding products.** A clinician or pharmacist can help select an over-the-counter option that fits your conditions and medications.

GET MEDICAL GUIDANCE

Severe or worsening abdominal pain, persistent vomiting, a swollen/distended abdomen, inability to pass stool or gas, blood/black stool, fever, or dehydration is outside this guide.

Other side effects

Diarrhea, reflux, belching, fatigue, and abdominal discomfort can occur. Use smaller meals and avoid personal triggers, but report severe, persistent, or worsening symptoms. Do not self-adjust medication.

WHEN MEAT OR SHAKES SOUND AWFUL

Protein is a category, not a single food

Food aversion can change. Keep multiple textures, temperatures, and sources available.

If this is hard...	Try this route
Dense meat	Flaked fish, eggs, yogurt, cottage cheese, tofu, lentil soup, shredded chicken in broth.
Sweet shakes	Unflavored protein in soup/oatmeal if approved; milk; savory cottage cheese; eggs; tuna pouch.
Large volume	Half portions, concentrated anchors, or four planned mini-feedings.
Strong smells	Cold chicken, chilled yogurt, tuna pouch outdoors/ventilated, or room-temperature foods.
Chewing fatigue	Soft eggs, yogurt bowl, cottage cheese, soup, tender fish, tofu.
Dairy	Fish, eggs, poultry, lean beef, tofu, edamame, beans/lentils; combine plant sources across the day.

DECISION RULE

Do not keep forcing the protein source that currently disgusts you. Change the form, texture, temperature, or source while keeping the target visible.

THE GROCERY FRAMEWORK

Buy components, not fantasy meals

A good cart makes Tuesday easier. It does not depend on perfect meal prep or “diet food” nobody else wants.

Cart lane	Pick 2-4
Fast proteins	Rotisserie chicken, eggs, Greek yogurt, cottage cheese, tuna/salmon pouches, cooked shrimp, tofu.
Cook-once proteins	Chicken breast/thighs, lean beef, fish, pork tenderloin, beans/lentils.
Produce you will use	Frozen vegetables, salad kit, berries, apples, bananas, pre-cut vegetables, soup vegetables.
Easy carbohydrates	Microwave rice, potatoes, oats, beans, corn, whole-grain bread/tortillas, fruit.
Flavor	Salsa, seasoning blends, Greek-yogurt sauce, lemon, mustard, lower-fat dressing, hot sauce if tolerated.
Emergency shelf/freezer	Protein soups, tuna pouches, frozen fish/chicken, microwave vegetables, single-serve yogurt.

The household test

Can the same ingredients feed other people with different portions or add-ons? Taco bowls, sheet-pan dinners, breakfast-for-dinner, grilled protein with two sides, and build-your-own plates pass this test.

45-MINUTE PREP

Prepare decisions, not fourteen identical containers

The goal is a ready protein, ready produce, ready carbohydrate, and two backups.

Minutes	Action
0-5	Start oven/air fryer; put rice or potatoes on; season two proteins.
5-25	Cook proteins. Use one mild flavor profile so leftovers can become bowls, wraps, or salads.
25-35	Cook or portion vegetables; wash fruit; portion yogurt/cottage cheese.
35-42	Pack 2-3 grab meals; store components separately for flexible family meals.
42-45	Write the backup plan on the fridge: restaurant order, frozen meal upgrade, and no-cook plate.

Base formula

- Protein: sheet-pan chicken + hard-boiled eggs.
- Produce: frozen green beans + berries.
- Carbohydrate: roasted potatoes or microwave rice.
- Backups: Greek yogurt + tuna pouch + frozen entree with added protein/vegetables.

MAKE REPEATABILITY THE GOAL

A repeatable structure beat a perfect menu: visible protein, a few defaults, and a backup for the day the plan fell apart.

NO-COOK + CONVENIENCE

The plan has to survive a job, a family, and a tired Tuesday

Convenience is not failure. Unplanned convenience is simply harder to steer.

Situation	Build this
Gas station	Protein drink or tolerated dairy + fruit; jerky if tolerated + water; avoid making candy the only available energy.
Grocery deli	Rotisserie chicken + microwave vegetable + potato/rice cup.
Desk lunch	Tuna pouch + whole-grain crackers + fruit; or Greek yogurt + berries + nuts.
Frozen meal	Choose one with visible protein; add extra cooked protein or vegetables if needed.
Drive-through	Grilled chicken, burger/chili, or bowl; prioritize protein; choose the portion and sides you tolerate.
Nothing sounds good	Pick the smallest tolerable protein anchor and schedule a second opportunity.

MINIMUM VIABLE MEAL
Protein anchor + one tolerated plant food + fluid. Add carbohydrate/fat based on energy needs, appetite, and tolerance.

EATING OUT

Use a decision tree, not a forbidden-food list

Restaurants are not a test of moral character. They are a portion, preparation, and comfort problem you can solve.

- 1. **Choose the anchor.** Grilled, baked, roasted, steamed, or otherwise tolerable protein.
- 2. **Choose one produce side.** Vegetables, salad, beans, fruit, or soup.
- 3. **Choose the carbohydrate you actually want.** Rice, potato, tortilla, bread, pasta—portion it intentionally instead of declaring it banned.
- 4. **Control concentrated extras.** Sauce/dressing on the side; choose fried or creamy items deliberately, especially if fat worsens symptoms.
- 5. **Plan the exit.** Box half early or stop when comfortable. Do not force the restaurant portion.

Cuisine	Simple order
Steakhouse	Lean steak/fish + vegetable + potato; sauce/butter as tolerated.
Mexican	Chicken/steak bowl or fajitas + beans/rice + vegetables/salsa.
Breakfast	Eggs/egg whites + fruit or potatoes + toast if wanted.
Sandwich	Protein-forward sandwich; eat the filling first; add soup/fruit; stop comfortably.

CARBS + SUGAR

Remove the drama; keep the decision

Carbohydrates do not switch fat loss off. Total intake, food quality, adherence, activity, symptoms, and individual medical needs matter.

Use carbohydrates on purpose

- Pair many carb foods with protein and/or plants for a more complete meal.
- Choose portions that fit appetite and energy needs. Active days may feel different from sedentary days.
- Use fiber-rich choices often, but not as a purity rule. White rice, toast, or crackers may be easier during nausea.
- If you have diabetes, follow your clinician's glucose and medication plan; this guide does not adjust it.

Sugar does not require total avoidance

Frequent liquid sugar and easy-to-overeat sweets can crowd out nutrition, but a planned portion does not erase progress. Decide, portion, enjoy, and return to structure. The rebound from rigid prohibition can cost more than the food itself.

A USEFUL QUESTION

Is this food replacing a nutrition priority, aggravating symptoms, or turning into an unplanned pattern? If not, it may simply be part of a flexible life.

THE 14-DAY BUILD

Practice the system in four short blocks

This is not a detox. Nothing magical happens on Day 14. The purpose is to install and test the minimum system.

Block	Focus	Proof of completion
Days 1-3	Measure reality	You logged intake/tolerance and picked an eating rhythm.
Days 4-7	Build defaults	You have 3 meals, 2 backups, and a grocery pattern.
Days 8-10	Rehearse real life	You used the system at a restaurant/convenience situation.
Days 11-14	Make it resilient	You completed a review and wrote if/then plans.

The five daily checks

- Fluids: followed my approved plan or noted the barrier.
- Protein: used planned anchors or logged why I could not.
- Plants/fiber: included a tolerated source.
- Movement: did something appropriate for my current ability.
- Review: recorded symptoms, hunger, and one sentence about the day.

DAYS 1-3

Measure before you optimize

The first win is knowing what is actually happening—not guessing from one unusually low-appetite day.

1. **Pick your eating rhythm.** Three anchors, two meals + booster, or four mini-feedings.
2. **Set the working protein target.** Use your clinician's target or discuss the 80-120 g practical range.
3. **Create a fluid cue.** Choose three routines that trigger sips.
4. **Log without judgment.** Meals, approximate protein, fluids, hunger/fullness, symptoms, bowel movement, energy.
5. **Create the safety boundary.** Save your prescriber's contact instructions and identify urgent symptoms.

Do not change these yet

- Medication dose or timing
- Multiple food rules at once
- A dramatic calorie cut
- A new supplement stack
- A punishing exercise plan

DAY 3 REVIEW

Where did the system break: food availability, appetite, symptoms, time, portion size, taste, or an unrealistic target? Fix the environment first.

DAYS 4-7

Build defaults that reduce decisions

A default is a meal you can repeat without resentment and obtain on a normal week.

Choose your 3 + 2

- **Three default meals:** one fast, one family-style, one low-appetite.
- **Two emergency backups:** one shelf/freezer option and one restaurant/drive-through order.

Run one grocery trip

Buy two fast proteins, two cook-once proteins, three produce choices, two carbohydrates, two flavor tools, and two emergency options. Leave room for food the household already eats.

Test portion comfort

Serve less than your pre-medication default. Eat slowly. Stop at comfortable satisfaction. If the meal was too small to support the plan, schedule a small protein opportunity later rather than forcing the plate.

DAY 7 REVIEW

Which meal was easiest to finish, easiest to prepare, and easiest to repeat? Keep it. The system is allowed to be boring in the useful places.

DAYS 8-14

Practice recovery before you need it

A system is not proven on a perfect day. It is proven when work runs late, dinner is out, or the weekend gets messy.

1. **Use one real-life meal.** Order with the eating-out decision tree.
2. **Use one convenience meal.** Build the minimum viable meal instead of waiting for perfect food.
3. **Practice the next-meal return.** After an off-plan meal, resume normal structure without restriction or punishment.
4. **Review the trend.** Use the same scale conditions and avoid interpreting one reading.
5. **Write three if/then plans.** If nausea is mild, if I work late, if hunger returns, then I will...
6. **Choose the next 14-day focus.** Maintain, solve one barrier, or bring a pattern to your clinician.

COMPLETION STANDARD

You do not need 14 perfect days. You need evidence that you can notice, choose, adapt, and return.

SIMPLE MEAL EXAMPLES

Use patterns, not mandatory menus

Portions should follow your approved needs and comfortable tolerance. Protein values are approximate.

Appetite	Meal	Approx. protein
Normal	4 oz salmon + potato + cooked green beans	~25 g
Normal	Chicken burrito bowl with beans, rice, peppers, salsa	~35-45 g
Normal	Lean burger patty + roasted vegetables + bun/potato	~25-35 g
Small	Greek yogurt + berries + oats	~20-25 g
Small	2 eggs + egg whites + toast + fruit	~25 g
Small	Cottage cheese + fruit + whole-grain crackers	~25 g
Very low	Half protein drink now; half later, if tolerated	~20-30 g total
Very low	Small bowl of chicken/bean soup	~15-25 g
No meat	Tofu + rice + cooked vegetables	~20-30 g

Add a second mini-feeding when one small meal cannot do enough work. Repeated shortfalls deserve review with your care team.

PROGRESS

Use a dashboard, not one number

Body weight is useful data. It is not a daily verdict.

Signal	Cadence	What to look for
Body weight	Daily + weekly average, or 1-3x/week	Trend under similar conditions; choose the cadence that does not fuel distress.
Waist	Every 4 weeks	Same location, time, and tape tension.
Clothing/fit	Monthly	How one repeat item fits.
Nutrition	Weekly	Protein-anchor consistency, fluids, variety, and repeated low-intake days.
Function	Weekly	Energy, walking tolerance, daily tasks, and later, repeatable strength markers.
Symptoms	As needed	Pattern, severity, duration, trigger, and effect on fluids/food.

Expect noise

Water, sodium, carbohydrate intake, constipation, menstrual cycle, travel, sleep, and meal timing can move the scale independently of fat. Early rapid changes can include water. Judge a system over weeks, not forty-eight hours.

PLATEAUS

A pause is a data problem—not an emergency

Call it a plateau only after the trend has been flat for roughly 3-4 consistent weeks, not after a few days.

The 7-point plateau audit

1. Compare weekly averages under similar weighing conditions.
2. Check constipation, sodium, travel, cycle, and other sources of water-weight noise.
3. Review seven representative days—not your best day—for portions, drinks, bites, and weekends.
4. Check protein, fluids, sleep, and repeated under-eating that may be reducing energy/movement.
5. Compare current movement with your own recent baseline.
6. Confirm the meal system still fits appetite and schedule.
7. Bring persistent plateaus, symptoms, or treatment questions to the prescriber; do not self-adjust medication.

CHANGE ONE VARIABLE

After the audit, choose one modest behavior change for 10-14 days. Examples: restore a walk, measure one calorie-dense extra, rebuild weekend structure, or plan the afternoon anchor. Do not slash food across the board.

THE NEXT-MEAL RESET

One rough meal is not a failed week

Return at the next meal. You do not need to wait for Monday.

Do not punish the meal

- Do not starve the next day.
- Do not add excessive cardio as repayment.
- Do not wait for Monday.
- Do not turn one choice into an identity statement.

Run the three-step reset

1. **Name it accurately.** “That meal was larger/different than planned.”
2. **Resume the base.** At the next eating opportunity: comfortable protein anchor, tolerated produce, fluids, normal portions.
3. **Learn once.** Was the cause hunger, environment, emotion, alcohol, lack of options, or simple enjoyment? Make one adjustment only if a pattern exists.

IDENTITY SHIFT

You are not someone who never goes off plan. You are someone who returns quickly without punishment.

WHEN HUNGER COMES BACK

A louder signal does not mean you failed

Hunger may vary across the week, over time, with sleep/stress/activity, or for medical reasons. Treat it as information.

1. **Check basics.** Did protein, food volume, fluids, sleep, or meal timing change?
2. **Use planned volume.** Add vegetables, fruit, soup, beans, or potatoes as tolerated—not just snack foods.
3. **Restore structure.** A planned snack or earlier meal may work better than white-knuckling until dinner.
4. **Check the environment.** Visible, convenient foods drive decisions even when hunger is moderate.
5. **Escalate medical questions.** If medication effect seems different or hunger change is concerning, contact the prescriber. Do not change the dose yourself.

LONG-TERM SKILL

The goal is not never feeling hungry. It is recognizing hunger, feeding yourself deliberately, and stopping without panic.

IF TREATMENT CHANGES OR STOPS

Build a transition with your clinician before the transition

Research shows substantial average weight regain after withdrawal in semaglutide and tirzepatide trials. That is physiology and chronic-disease management—not a character flaw.

The maintenance conversation

- Why might treatment change, and what alternatives or monitoring does the prescriber recommend?
- What hunger or weight changes should trigger contact?
- Which meal rhythm, protein target, and activity routine should remain stable?
- How often will weight, waist, symptoms, and relevant labs be reviewed?
- What is the early-response plan for regain—before shame or all-or-nothing restriction takes over?

Keep the system visible

Maintain default meals, planned protein anchors, shopping structure, regular weighing cadence, sleep/movement cues, and quick recovery. These behaviors are not a guarantee against regain; they are the controllable layer of a medically guided plan.

See Sources [5]-[6] for withdrawal-trial evidence. Do not stop medication based on this guide.

PRACTICAL LESSONS

What to protect from Day 1

Use these practical reminders to build a routine that fits your own needs.

MAKE REPEATABILITY THE GOAL

A few repeatable meals and a protein-first structure were more useful than endlessly searching for the perfect diet.

WHEN LESS FOOD IS NOT BETTER

Low hunger can make a very low intake feel like success. But if protein, fluids, energy, and function are repeatedly slipping, the scale is not telling the whole story.

BUILD THE FOUNDATION EARLY

Treat efforts to preserve muscle and build a long-term routine as part of weight loss from the beginning.

RETURN AT THE NEXT MEAL

A rough weekend does not erase the week. Use your next planned meal to return to the routine.

Individual responses vary. Keep what helps, record what does not, and involve your care team where the decision becomes medical.

FAQ / STARTING

The questions people ask when appetite gets quiet

Short answers first. Use the relevant playbook when you need more.

I am barely hungry. Do I really need to eat?

You still need fluids and adequate nutrition. Use small planned opportunities and the priority ladder. Repeated inability to meet basic needs or persistent symptoms belongs with your clinician.

How much protein do I need?

There is no single formula for everyone with obesity. Use your clinician's target, or discuss an 80-120 g/day practical range from the joint advisory and divide it into tolerable anchors.

What do I eat first?

Protein first when volume is limited, then tolerated produce/fiber, then carbohydrate/fat based on needs and comfort.

Protein shakes make me sick.

Do not force them. Rotate to eggs, fish, yogurt/cottage cheese if tolerated, tofu, beans/lentils, soup, or smaller portions across the day.

Do carbs prevent fat loss?

No. Use portions that support your overall plan, energy, activity, glucose care, and adherence.

Do I need to eliminate sugar?

No. Limit patterns that crowd out nutrition or trigger symptoms, but a planned portion does not cancel progress.

FAQ / PROGRESS

The questions that show up after the first few weeks

The answer is usually better data, a smaller change, or a clinician conversation—not panic.

I am losing quickly. Is faster always better?

No. Early change may include water, and an aggressive pace can make nutrition and muscle preservation harder. Report concerning rapid loss, weakness, dizziness, dehydration, or poor intake.

How often should I weigh?

Daily with a weekly average or 1-3 times weekly can work. Use consistent conditions and choose a cadence that does not worsen distress or disordered behavior.

The scale stopped. What now?

Confirm a 3-4 week trend, audit water-weight noise and seven real days, then change one behavior for 10-14 days.

I ate badly this weekend. Did I ruin everything?

No. Resume normal structure at the next meal. Do not starve or punish.

What happens if I stop medication?

Do not stop based on this guide. Withdrawal trials show regain is common on average; plan treatment changes and monitoring with your prescriber.

How do I avoid regaining everything?

No system can promise that. Build repeatable food, movement, sleep, tracking, and response routines—and use ongoing medical care for a chronic condition.

YOUR NEXT PHASE

Phase 1 builds the floor. Phase 2 builds capacity.

The Hunger Switch owns nutrition, appetite-aware meal structure, adherence, recovery, and the first layer of muscle protection.

Hunger Switch / Phase 1	Metabolic Upgrade / Phase 2
Protein and nutrition priorities	Structured resistance-training program
Meal builder and appetite adaptations	Exercise selection and technique framework
Grocery, prep, convenience, and restaurants	Sets, reps, progression, and recovery
Progress trends and plateau audit	Strength and body-composition tracking
Sleep/movement foundations	Fitness progression and metabolic capacity
Maintenance behaviors and transition questions	Recomposition phase and next-stage goals

START HERE

For the next 14 days, use the companion workbook. Do not add complexity because you are excited. Prove the base first.

Resistance training is important for muscle preservation, but individualized exercise should match your ability, conditions, and clinician guidance. Phase 2 expands the training layer without turning Phase 1 into a gym manual.

SOURCES

Evidence behind the guardrails

This is a practical guide, not a systematic review. These sources support the main safety, nutrition, activity, and maintenance statements.

- [1] Mozaffarian D, Agarwal M, Aggarwal M, et al. Nutritional priorities to support GLP-1 therapy for obesity: a joint advisory. *Obesity*. 2025. <https://onlinelibrary.wiley.com/doi/10.1002/oby.24336>
- [2] U.S. FDA. Wegovy (semaglutide) Prescribing Information / Medication Guide, 2025. https://www.accessdata.fda.gov/drugsatfda_docs/label/2025/215256s024lbl.pdf
- [3] U.S. FDA. Zepbound (tirzepatide) Prescribing Information / Medication Guide, 2026. https://www.accessdata.fda.gov/drugsatfda_docs/label/2026/217806s042lbl.pdf
- [4] U.S. Department of Health and Human Services. Physical Activity Guidelines for Americans. <https://odphp.health.gov/our-work/nutrition-physical-activity/physical-activity-guidelines/current-guidelines>
- [5] Wilding JPH, et al. Weight regain and cardiometabolic effects after withdrawal of semaglutide: STEP 1 extension. *Diabetes Obes Metab*. 2022. <https://pmc.ncbi.nlm.nih.gov/articles/PMC9542252/>
- [6] Aronne LJ, et al. Continued treatment with tirzepatide for maintenance of weight reduction: SURMOUNT-4. *JAMA*. 2024. <https://pmc.ncbi.nlm.nih.gov/articles/PMC10714284/>

USING CURRENT GUIDANCE

Evidence and medication labels change. This edition was reviewed in September 2026. Readers should use the current Medication Guide and current clinician advice.

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