YOU'RE NOT CRAZY.

It's the Shot.

Burping 50 times a day? Haven't pooped in 5? Hair in the drain?
The full GLP-1 manual — 36 weird things the shot does to you,
and exactly what to do about each one.

BY MAREN WHITLOCK

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You're Not Crazy.

It's the Shot.

Burping. Pooping. Hair in the drain.
The full GLP-1 manual.

This guide is education. It is not medical advice. It is not a substitute for a relationship with a licensed clinician. Always talk to your own provider before starting, stopping, or changing any medication.

THE LETTER

If you are reading this in the bathroom —

welcome. You are exactly the person I wrote this for.

You started one of these medications because something needed to change. Maybe it was your blood sugar. Maybe it was the way you felt walking up stairs. Maybe it was a number on a chart. Whatever brought you here, it was a real decision and you made it for real reasons.

And then — somewhere around week three, or six, or twelve — the side of the road got weird. You started burping fifty times a day. You stopped going to the bathroom. You found hair in the drain. Your dinner tasted like a battery. You were freezing in a 72-degree room. You woke up at 3 a.m. for no reason. You looked at a piece of cake at your niece's birthday and felt nothing.

And nobody warned you. And the internet is contradictory. And your doctor has fifteen minutes. And you started to wonder, quietly, in the part of your brain that you do not say out loud:

Am I going crazy?

You are not crazy. It is the shot.

Every single thing in this book is a known, documented, mechanically-explainable effect of the class of medication you are on. Not in your head. Not character flaws. Not weakness. Pharmacology.

This guide covers 36 of them. For each one, you will find what it feels like, what is actually happening in the body, three things to try at home, questions to bring to your clinician, and the specific red flags that mean call the same day or go to the ER. No doses. No brands. No hype. Just the map.

Read what you need. Skip what you do not. Hand it to a friend who is staring at the same toilet you were. And the next time something weird happens, do not Google for three hours at midnight. Open this book.

— Maren

READ THIS FIRST

You Made the Right Call.

You did not do this because you were weak. You did it because you were tired of losing the same fight with your own body for the tenth year in a row.

And something is working. The food noise — that constant negotiation with the pantry, the menu, the leftovers — has quieted for the first time in decades. Your A1c is moving in the right direction. Your joints are lighter. Your blood pressure is calmer. The seatbelt fits. The stairs are easier. You are sleeping through the night. The cravings that used to run the show are running in the background now.

This drug is doing real work in your body. The trials show it, and more importantly — you feel it. You are not weak for taking it. You are informed.

So Why Does Everything Feel Weird?

Because every drug that changes your gut, your appetite hormones, your brain reward system, and your metabolism at the same time is going to come with a body adjustment. That is what these 36 things are. Adjustments. Not warnings. Not signs that you are broken. Not signs that you should quit.

Almost every one of them can be softened, shortened, or fixed outright with three simple changes you can start tonight. Most of them fade in the first eight weeks. A few of them are worth a phone call to your clinician — and this book will tell you exactly which ones and when.

Your care team meant well. They were rushed. They handed you a prescription and a two-line warning about nausea. Nobody sat you down and said here is what to expect in month one, month three, month six — and here is what to do about each one. That is what this book is. The conversation you needed and did not get.

How to Use This Book.

Not front to back. Flip to the symptom that is bothering you today. Read the three fixes. Try them tonight. Give it three to five days.

If the three fixes do not move the needle, or if you hit any of the red flags in the CALL SAME DAY IF box, pick up the phone. Do not wait it out. Do not Google harder. Call.

You are not a bad patient. You are not a drama patient. You are the informed patient your clinician wishes they had time to make you. Every question in the ASK YOUR CLINICIAN box is worth bringing to your next appointment.

This is education, not medical advice. Talk to your own clinician before changing any medication. And — most of these will pass. You are going to be okay.

THE MAP

36 Things The Shot Does

Find what is happening to you. Jump straight there.

How to use this book. Each chapter is short — two to three pages — and follows the same shape: what it feels like, what is actually happening, three things to try, questions for your clinician, and the red flags that mean stop and call. You do not have to read in order. Find your symptom, read the chapter, take it to your appointment.

CHAPTER

01 Constipation

This is common. It has a name. It usually passes. Here is what to try tonight.

"I haven't pooped in five days."

WHAT IT FEELS LIKE

Five days. Five days and counting. You are standing in the bathroom at 7 a.m. giving the toilet a look that could melt steel. Your jeans don't fit the way they did last Tuesday. You feel like a balloon someone forgot to release. And the part nobody warned you about — you are also a little afraid. Because five days is a long time. Yes, this is the shot. No, you are not broken.

WHAT IS ACTUALLY HAPPENING

GLP-1 medications slow gastric emptying by thirty to seventy percent. The same brake that quiets your appetite also quiets the entire downstream conveyor belt. Less movement up top means less movement down below. This is predictable pharmacology, not a mystery and not your fault.

THREE THINGS TO TRY

- Hit a hydration target — roughly half your body weight in ounces of water per day. Most people on the shot are quietly dehydrated and do not know it.
- Walk for ten to fifteen minutes after every meal. Gastric motility responds to movement more reliably than to any pill on the shelf.
- Front-load fiber from food, not from heroic supplements — chia, ground flax, berries, oats, a pear, cooked greens. Add slowly. Sudden fiber on a slowed gut makes things worse before better.

ASK YOUR CLINICIAN

- Is magnesium glycinate appropriate for me, and at what dose, given my other medications?
- Should we check basic labs — electrolytes, thyroid, ferritin — before adding anything new?
- If this does not resolve in another week, what is the next step you would recommend?

CALL THE SAME DAY IF

- More than seven days without a bowel movement
- Severe abdominal pain, especially with fever
- Vomiting that will not stop
- Blood in stool or black, tarry stool

CHAPTER

02 Hard, Painful, Incomplete Stools

You are not alone in this. Most people on this drug hit some version of it. The fixes are simple.

"When I do go, it's like passing rocks. And I'm not done."

WHAT IT FEELS LIKE

You finally go. You think the war is over. And then you stand up and your body says: nope, still in here. Or the going itself was a small interrogation. People do not talk about this part. They should. It is one of the most common complaints on every GLP-1 forum on the internet.

WHAT IS ACTUALLY HAPPENING

When transit slows, water gets reabsorbed in the colon for longer than usual. The stool dries out and compacts. At the same time, the stretch receptors that tell your brain you are finished get duller — so the signal to stand up and walk away arrives late, or arrives in pieces.

THREE THINGS TO TRY

- Put a small footstool under your feet so your knees come up above your hips. This is not a gimmick — it changes the angle and the work involved.
- Do not strain. If nothing is happening in five minutes, get up, walk, drink water, try again in an hour. Straining is how hemorrhoids and fissures happen.
- Add a tablespoon of ground flax or chia to breakfast daily. Soft, gentle, food-based bulk works better than stimulant laxatives long-term.

ASK YOUR CLINICIAN

- Is an osmotic option like a daily stool softener appropriate for me to use short-term?
- Could a fiber supplement be added safely given my current medications?
- When is the right time to consider lowering my dose if this persists?

CALL THE SAME DAY IF

- Bright red blood on the paper that does not stop
- Severe pain during or after a bowel movement
- A visible lump or prolapse
- Pencil-thin stools that stay that way

CHAPTER

03 Sulfur Burps

This is your body adjusting — not your body breaking. Three things can move the needle fast.

"I burp fifty times a day and it smells like rotten eggs."

WHAT IT FEELS LIKE

There is a Reddit community with thousands of members called r/SulfurBurps. That is how alone you are not. You are in a meeting and you taste eggs you did not eat. You burp into your own hand and recoil. Your dog leaves the room. This is, in a strange way, very funny. It is also miserable.

WHAT IS ACTUALLY HAPPENING

Food sits in the stomach much longer than usual. Sulfur-producing bacteria are opportunists — they ferment undigested protein and certain foods, and the longer the buffet stays open, the more hydrogen sulfide gas they make. That gas is what is coming up. It is mechanical, not mystical.

THREE THINGS TO TRY

- Pull back on the highest-sulfur foods for two weeks and see — eggs, garlic, onions, cruciferous vegetables, whey protein powder, and red meat are the usual suspects.
- Smaller, more frequent meals beat three big ones. A slower stomach can handle four small inputs better than two big ones.
- Peppermint tea or a piece of fresh ginger after meals helps a lot of people. Cheap. Low risk. Try before you reach for anything fancier.

ASK YOUR CLINICIAN

- Is a digestive enzyme appropriate for me to try with meals?
- Could a probiotic be useful for me, and which strain would you suggest?
- Is the burping severe enough that we should reconsider dose timing or level?

CALL THE SAME DAY IF

- Burping accompanied by vomiting that will not stop
- Severe upper abdominal pain that radiates to the back
- Yellow tint to the skin or eyes
- Fever along with the digestive symptoms

CHAPTER

04 Nausea Waves

A known effect. A known mechanism. A known fix. You are not making this up.

"I'm queasy all day for three days after my shot."

WHAT IT FEELS LIKE

It is not throwing up. It is worse, somehow, because it never quite resolves. A low gray nausea that follows you around for seventy-two hours after the injection like a smell you cannot place. You forget what hungry feels like. You forget what neutral feels like. Then on day four, the fog lifts and you remember you have a personality.

WHAT IS ACTUALLY HAPPENING

GLP-1s talk directly to the vomiting center in your brainstem and to the vagus nerve. Combined with the slowed stomach, this peaks twenty-four to seventy-two hours after the injection — exactly when you feel it. The brain is doing what the drug tells it to do.

THREE THINGS TO TRY

- Move the injection to a night when you have the next day open. Sleep through the peak.
- Eat smaller, blander, room-temperature meals on injection day and the day after. Strong smells make this worse.
- Ginger — tea, chews, crystallized, capsules. There is real research behind it for nausea. Lemon water and cold tart things also help some people.

ASK YOUR CLINICIAN

- Could we slow the titration if the nausea is this disruptive?
- Is there an anti-nausea option that is safe to use short-term with this medication?
- Is the dose level still right for me, or should we step back one notch?

CALL THE SAME DAY IF

- Vomiting that lasts more than twenty-four hours
- Unable to keep liquids down for twelve hours
- Signs of dehydration — dizziness, dark urine, confusion
- Severe abdominal pain along with the nausea

CHAPTER

05 Early Satiety

The drug is doing what it is supposed to do. This is the price of admission for month one or two. It softens.

"Three bites and it feels like food from yesterday is still in there."

WHAT IT FEELS LIKE

You sit down hungry. You pick up the fork. You take three bites of the salad and you are full in a way that does not feel like fullness — more like a small traffic jam at the base of your throat. You stare at your plate. The plate stares back. Someone at the table says are you not eating that and you do not know how to answer.

WHAT IS ACTUALLY HAPPENING

Your stomach is emptying at roughly thirty to fifty percent of its normal speed. The food from lunch is still on the conveyor belt when dinner shows up. The stuck feeling is delayed gastric emptying, not a physical blockage. It is the drug working — and overworking.

THREE THINGS TO TRY

- Five small meals beats three big ones. Spread the protein across the day so the floor never drops out from under you.
- Sit upright for at least an hour after eating. Lying down stalls an already slow stomach.
- Protein first, then vegetables, then carbs. If you can only get three bites in, make those three bites the protein.

ASK YOUR CLINICIAN

- Am I hitting the protein floor I need to protect lean mass — what number should I aim for?
- Is my current dose appropriate, or are we overshooting the appetite suppression I need?
- Should we run a nutrition baseline to check for any developing gaps?

CALL THE SAME DAY IF

- Cannot keep down food or water for more than twelve hours
- Persistent vomiting after meals
- Sudden severe upper abdominal pain
- Weight loss that feels too fast or out of control

NEXT STEP · THE EAT ANYWAY GUIDE

You can barely finish three bites — and you are terrified about losing muscle.

For women on the shot who cannot force another chicken breast — and know the muscle math matters.

- The protein floor you actually need per day on a GLP-1 — and the six foods that hit it without volume.
- The five-small-meals structure that works when appetite is gone but the day is long.
- How to counter the burp-and-nausea reflex so you can finish the food that is already on the plate.

https://www.marenwhitlock.com/eat-anyway · $14.99

CHAPTER

06 Acid Reflux At Night

Nothing about this is a red flag on its own. Try the three things. Most people are back to baseline in weeks.

"I lie down and it burns up to my throat."

WHAT IT FEELS LIKE

Bedtime used to be the easy part of the day. Now you brace for it. You lie down and within minutes there is a hot line traveling up from your stomach to the back of your throat. You sit up. It settles. You lie back down. It comes back. You sleep half-propped on three pillows like a wounded Victorian and you wonder when this stopped being temporary.

WHAT IS ACTUALLY HAPPENING

Slower stomach emptying plus a relaxed lower esophageal sphincter — the valve at the top of the stomach — equals nighttime reflux. The contents have nowhere to go, gravity goes away when you lie down, and the valve is doing a sloppy job of holding the line.

THREE THINGS TO TRY

- Stop eating three hours before bed. This one is non-negotiable. Most reflux on the shot is solved by this alone.
- Elevate the head of the bed six inches with risers under the bedposts — not just extra pillows, which crunch your neck without helping the stomach.
- Skip the late-night trigger foods — coffee after 2 p.m., chocolate, tomato sauce, anything fried, alcohol, mint. Sleep on your left side.

ASK YOUR CLINICIAN

- Is a short course of an acid-reducing medication appropriate for me?
- Should we evaluate whether the dose is contributing more than necessary to this reflux?
- When should I be more aggressive about getting this looked at?

CALL THE SAME DAY IF

- Difficulty swallowing or food feeling stuck
- Vomiting blood or coffee-ground material
- Black or tarry stools
- Chest pain that could be cardiac — never assume reflux without ruling out the heart

CHAPTER

07 Bloating And Distension

This shows up in the trial data. Your clinician has seen it before. You can handle it — and this chapter shows you how.

"I look six months pregnant by 3 p.m."

WHAT IT FEELS LIKE

You buttoned your jeans this morning. By the time you get to your 3 p.m. meeting, you are unbuttoning them under the table and praying nobody notices. Your reflection in the bathroom mirror surprises you. You did not eat that much. You did not eat that much.

WHAT IS ACTUALLY HAPPENING

Slow transit means gas gets trapped instead of moving along. Fermentation by gut bacteria — feeding on food that is sitting longer than usual — produces gas faster than the slowed gut can clear it. By mid-afternoon you have a small balloon's worth of nowhere-to-go in your midsection.

THREE THINGS TO TRY

- Walk after every meal. Ten minutes. Non-negotiable. This single habit changes more than any pill.
- Reduce the high-FODMAP suspects for two weeks and see — onions, garlic, beans, certain fruits, sugar alcohols. Reintroduce one at a time.
- Simethicone — the active ingredient in Gas-X — is cheap, safe, and works for many people. Worth keeping in the bag.

ASK YOUR CLINICIAN

- Could a digestive enzyme or short course of a probiotic help my situation?
- Are there foods in my current pattern that may be working against the slowed gut?
- If this is severe, should we look at adjusting the dose?

CALL THE SAME DAY IF

- Bloating with severe, sharp pain
- Bloating with fever or vomiting
- Sudden, dramatic increase in size — especially with shortness of breath
- Bloating that does not change with bowel movements over many days

CHAPTER

08 Food Aversions

This is common. It has a name. It usually passes. Here is what to try tonight.

"I used to love chicken. Now the smell makes me gag."

WHAT IT FEELS LIKE

You walk into your own kitchen and the smell of last night's leftovers reorganizes your face. Coffee — your one true love — has turned on you. Chicken is the enemy. The smell of grease at a restaurant becomes a personal insult. You are not crazy. Your sense of smell and taste have actually shifted.

WHAT IS ACTUALLY HAPPENING

GLP-1 medications change the way your brain processes food signals. Smell receptors and taste perception both shift, and the dopamine response to food — the reward circuit — flattens. Foods that used to land now register as neutral or repulsive. Coffee, meat, and fried foods are the most-reported aversions on every GLP-1 community.

THREE THINGS TO TRY

- Lean into the foods that still taste okay. This is not the time for nutritional perfectionism. Tolerated calories are calories.
- Cold or room-temperature foods often work better than hot ones — less aroma, less trigger.
- Smoothies, soups, and protein shakes carry nutrition without strong food smells. Use them as bridges, not as your only intake.

ASK YOUR CLINICIAN

- Is a basic nutrient panel appropriate to check whether I'm developing any gaps?
- Could a multivitamin or protein supplement be useful in my current pattern?
- Is this dose level over-suppressing my appetite in a way we should adjust?

CALL THE SAME DAY IF

- Complete inability to eat for more than a day
- Rapid weight loss that feels out of control
- Signs of malnutrition — weakness, hair loss, dizziness
- Food aversions accompanied by depression or persistent flat mood

CHAPTER

09 Hair Shedding

You are not alone in this. Most people on this drug hit some version of it. The fixes are simple.

"My ponytail is half the size it was."

WHAT IT FEELS LIKE

You see it in the shower drain first. Then on your pillow. Then on the back of your sweater. You hold your ponytail in your hand and it feels smaller. You count weeks since you started the shot and it lines up almost exactly. Nobody warned you. Cleveland Clinic estimates a quarter to a third of people on these drugs experience some version of this.

WHAT IS ACTUALLY HAPPENING

Rapid weight loss — any rapid weight loss, not just from the shot — triggers a condition called telogen effluvium. The body, sensing what it reads as a stress event, shifts a chunk of hair follicles into the resting phase. Two to four months later, those hairs shed. Lower protein intake and lower iron during the same period make it worse.

THREE THINGS TO TRY

- Hit a protein floor every single day. For most adults on a GLP-1, that is at least 0.7 grams per pound of goal body weight. Hair is made of protein. No protein, no hair.
- Eat iron-rich foods or talk to your clinician about supplementation — red meat if tolerated, lentils, spinach, fortified cereals. Iron and ferritin are common gaps.
- Be patient and be gentle. The shedding usually stops within six to nine months as weight stabilizes. Stop washing every day, stop tight ponytails, stop heat styling for now.

ASK YOUR CLINICIAN

- Can we run ferritin, iron, vitamin D, B12, and a basic thyroid panel?
- Is biotin appropriate for me — or are we addressing the wrong lever?
- Is my rate of weight loss in the range we should slow down?

CALL THE SAME DAY IF

- Hair loss in patches, not all-over thinning
- Hair loss with scalp pain, redness, or itching
- Hair loss accompanied by extreme fatigue, cold intolerance, or weight changes that don't match your eating
- Eyebrow or eyelash loss alongside the scalp shedding

And still — your hair is growing. The follicles are alive. The drain is loud because a synchronized reset is loud. The mirror is quiet again in three to six months.

CHAPTER

10 Cold All The Time

This is your body adjusting — not your body breaking. Three things can move the needle fast.

"I'm freezing and everyone else is fine."

WHAT IT FEELS LIKE

Your office is the same temperature it has been for years. Your house is the same. Your husband is in a T-shirt. You are in a hoodie, with socks, holding a cup of tea, and you are still cold. You wonder if the thermostat is broken. The thermostat is fine. You are the thermostat now.

WHAT IS ACTUALLY HAPPENING

When you eat less, you generate less heat. Thermogenesis — the body's furnace — runs on the food coming in. Drop the input and the output drops with it. The body, sensing what it reads as scarcity, also dials down peripheral circulation to keep the core warm. Hands and feet pay the tax first.

THREE THINGS TO TRY

- Eat warm meals. Soup, broth, oatmeal, hot tea. Internal warmth from food works faster than any sweater.
- Resistance training builds the tissue that burns heat. Muscle is metabolically expensive — that is the point.
- Layer your hands and feet specifically — wool socks, fingerless gloves at your desk. The core is fine. The periphery is the part the body has stopped subsidizing.

ASK YOUR CLINICIAN

- Can we run a thyroid panel? Cold intolerance can be a thyroid signal, not just a calorie one.
- Is my current rate of weight loss sustainable, or are we losing muscle faster than we should?
- Should we look at my iron and ferritin levels?

CALL THE SAME DAY IF

- Cold along with extreme fatigue, hair loss, and weight changes — possible thyroid
- Cold with confusion, slurred speech, or shivering you cannot stop
- Cold with numbness or color changes in fingers or toes that do not resolve with warming
- Cold accompanied by a slow heart rate

And still — the drug is working. Your body is running efficient. A jacket at dinner is not a warning sign. It is a receipt.

CHAPTER

11 Gallbladder Pain

A known effect. A known mechanism. A known fix. You are not making this up.

"It's like a knife under my right ribs after eating."

WHAT IT FEELS LIKE

You finish dinner. Twenty minutes later — sometimes two hours later — a hot, sharp pain shows up under your right rib cage. It can radiate to your back, to your right shoulder. It builds, sits, and then slowly fades. You think it was the dinner. The next time it happens, you think it might not be the dinner.

WHAT IS ACTUALLY HAPPENING

Rapid weight loss — any rapid weight loss, including from the shot — supersaturates bile with cholesterol. The gallbladder, which stores and releases bile, becomes a more hospitable place for stones to form. This is a known risk with these medications, and the Mayo Clinic flags it on the tirzepatide label.

THREE THINGS TO TRY

- Do not skip fat entirely. A small amount of healthy fat at each meal keeps the gallbladder contracting instead of stagnating.
- Hydrate. Bile is a fluid. Dehydration thickens it. Most people on the shot are quietly dehydrated.
- Slow your rate of weight loss if it is feeling too fast. Faster is not better here.

ASK YOUR CLINICIAN

- Should we image my gallbladder if this pain pattern continues?
- Is the rate of weight loss we are seeing in the safe zone?
- Are there warning signs I should be especially watching for?

CALL THE SAME DAY IF

- Severe pain lasting more than a few hours — this is a same-day call
- Pain with fever, chills, or vomiting — go to the ER
- Yellowing of the skin or whites of the eyes — go to the ER
- Pain with chest tightness or shortness of breath — call 911

And still — the number on the scale is moving because your body is finally letting go of what it did not need. The gallbladder is a fixable footnote, not the whole story.

CHAPTER

12 Skin Sensations And Allodynia

The drug is doing what it is supposed to do. This is the price of admission for month one or two. It softens.

"My skin hurts when my shirt touches it."

WHAT IT FEELS LIKE

Your sweater feels like sandpaper. The waistband of your jeans feels too tight even when it is not. A hug from your partner is suddenly uncomfortable. You ask yourself whether you are losing your mind. You are not. This one is new enough that some doctors do not know about it yet.

WHAT IS ACTUALLY HAPPENING

Allodynia — pain from things that are not supposed to hurt — and dysesthesia — weird skin sensations — have only recently been recognized in the literature as side effects of semaglutide and tirzepatide. The 2026 case reports out of PMC describe a small but real cluster of patients. It appears to be dose-dependent. It usually resolves with discontinuation and may resolve on its own.

THREE THINGS TO TRY

- Wear soft, loose, natural fibers — cotton, silk, modal. Tags off, seams turned out if you have to.
- Document what triggers it, when it happens, how long it lasts. This is new science. Your data matters.
- Avoid scratching or rubbing the area — that often makes the nerves more reactive, not less.

ASK YOUR CLINICIAN

- Have you seen this before — and if not, here is a recent PMC case series I want to bring to your attention.
- Could the dose be the driver, and is it worth a small step down to see if it resolves?
- Should we involve a neurologist if this persists?

CALL THE SAME DAY IF

- Skin sensations with weakness in an arm or leg
- Skin sensations with vision changes, slurred speech, or confusion — call 911
- Skin sensations with a visible rash, blistering, or fever
- Skin pain severe enough to disrupt sleep for more than a few nights

CHAPTER

13 Metallic Taste

Nothing about this is a red flag on its own. Try the three things. Most people are back to baseline in weeks.

"Coffee tastes like pennies now."

WHAT IT FEELS LIKE

You take a sip of your morning coffee and your mouth says: pennies. You take a bite of steak and it tastes like the bottom of an old purse. This one is annoying in a way that feels small until you realize it is making it harder to eat anything at all.

WHAT IS ACTUALLY HAPPENING

GLP-1 medications can shift taste perception — a phenomenon called dysgeusia. Zinc levels, hydration, and the medication itself all play a role. The taste shift usually softens over time but can be persistent.

THREE THINGS TO TRY

- Rinse your mouth with a little baking soda dissolved in water before meals. It neutralizes the taste shift for some people.
- Use plastic or wooden utensils for the meals where metal tastes worst — metal forks make this worse for some people.
- Marinades, citrus, and acidic foods can help override the metallic note. Lemon water with meals helps a lot of people.

ASK YOUR CLINICIAN

- Could a zinc deficiency be contributing here — should we test?
- Is the dose appropriate, or is this signaling we are overshooting?
- Are there nutrient gaps worth checking given the changed taste landscape?

CALL THE SAME DAY IF

- Metallic taste with mouth sores or burning that does not resolve
- Metallic taste with vomiting blood or coffee-ground material
- Metallic taste with a swollen tongue or trouble breathing — call 911
- Sudden complete loss of taste, not just a shift

CHAPTER

14 Crushing Fatigue

This shows up in the trial data. Your clinician has seen it before. You can handle it — and this chapter shows you how.

"I need a nap every single afternoon."

WHAT IT FEELS LIKE

Two p.m. arrives. The room gets warmer. The chair gets heavier. You feel like someone is slowly lowering a velvet curtain over your face. You used to be a morning person. Now you are a nine-to-noon person and an unconscious-by-three person.

WHAT IS ACTUALLY HAPPENING

Lower calorie intake plus electrolyte losses plus disrupted cortisol rhythm plus changed sleep architecture all add up. Your body is running on less fuel, and your sympathetic nervous system is doing different things than it used to. The afternoon crash is a downstream signal.

THREE THINGS TO TRY

- Protein at breakfast within an hour of waking. Twenty-five to thirty-five grams. This single change moves the afternoon crash more than any caffeine fix.
- Electrolytes — sodium, potassium, magnesium — added to water once or twice a day. Most people on the shot are quietly depleted.
- Get outside within thirty minutes of waking for ten minutes. Morning light anchors the cortisol curve so it lands properly in the afternoon.

ASK YOUR CLINICIAN

- Can we check ferritin, vitamin D, B12, and a thyroid panel?
- Is my current rate of intake low enough that we are creating this fatigue?
- Should we look at sleep architecture if this does not resolve?

CALL THE SAME DAY IF

- Fatigue with shortness of breath, especially climbing stairs
- Fatigue with chest pain or palpitations
- Fatigue with rapid, unexplained weight loss
- Fatigue that prevents you from working or caring for yourself

And still — many people find that once the first two months pass, their steady energy is higher than it has been in years. This is the dip before the plateau.

NEXT STEP · THE FEEL IT AGAIN GUIDE

The 2 p.m. crash is now a 10 a.m. crash — and coffee makes it worse.

For women whose energy fell through the floor on this drug and who are done pretending it is fine.

- The cortisol reset — why the shot flattens your morning energy curve and how to rebuild it.
- The 30-minute morning protocol that stabilizes energy for the entire day without more caffeine.
- The exact sleep architecture that lets your body actually recover on a GLP-1.

https://www.marenwhitlock.com/feel-it-again · $14.99

CHAPTER

15 Dizziness When Standing

This is common. It has a name. It usually passes. Here is what to try tonight.

"I stand up and the room tilts."

WHAT IT FEELS LIKE

You stand up from the couch and the room tilts. You hold onto the wall for a second. It passes. It happens again in the kitchen. You start standing up slowly, the way your grandmother used to. You are not your grandmother. This is the shot, plus dehydration, plus the meal you skipped.

WHAT IS ACTUALLY HAPPENING

Three things stack: dehydration is rampant on these drugs because you forget to drink, electrolyte shifts are common, and when you eat less your blood pressure can sit a little lower than usual. Stand up too fast and the autonomic system does not catch up in time. The result is the tilt.

THREE THINGS TO TRY

- Drink water before you stand up in the morning. Keep a glass by the bed. This single habit catches most of it.
- Add salt to your water once a day if your clinician agrees. Most adults on a GLP-1 are quietly under-sodiumed.
- Stand up in two stages — sit at the edge of the bed or chair for ten seconds, then stand. Give your nervous system the runway.

ASK YOUR CLINICIAN

- Can we check my blood pressure standing and sitting to look for orthostatic patterns?
- Should we add electrolytes systematically, and what is the right formulation for me?
- If I am on a blood pressure medication, do we need to revisit the dose now that I have lost weight?

CALL THE SAME DAY IF

- Dizziness with chest pain, shortness of breath, or palpitations — call 911
- Dizziness that causes you to fall or pass out
- Dizziness with confusion, slurred speech, or weakness on one side — call 911
- Dizziness with a severe headache unlike any you have had

CHAPTER

16 Injection Site Reactions

You are not alone in this. Most people on this drug hit some version of it. The fixes are simple.

"It welts and itches for three days."

WHAT IT FEELS LIKE

You inject. Within an hour, there is a small red disc where the needle went in. It itches. It welts. It looks like a mosquito bite that got into management. You scratch it once and regret it. By day three it has faded to a pink memory. Then injection day comes around again.

WHAT IS ACTUALLY HAPPENING

Local histamine response, mild skin sensitivity to the preservatives or the active ingredient, or technique — needle angle, depth, site rotation — all contribute. Most injection site reactions are mild and self-limiting. A small minority are signaling a real allergy and need attention.

THREE THINGS TO TRY

- Rotate sites — abdomen, thigh, upper arm — and do not reuse the same exact spot twice in a row.
- Let the medication come to room temperature for thirty minutes before injecting. Cold liquid stings more and welts more.
- Inject perpendicular to the skin, not at an angle. Hold the pen in place for the full count after the click. Pull straight out.

ASK YOUR CLINICIAN

- Is my technique correct — can we review it together?
- Is this reaction within the normal range, or is it signaling something we should act on?
- Should we try a different brand or formulation if this continues?

CALL THE SAME DAY IF

- A welt that grows beyond a couple of inches
- Hives spreading away from the injection site
- Swelling of the face, lips, or tongue — call 911
- Difficulty breathing after injection — call 911

CHAPTER

17 Heart Racing At Rest

This is your body adjusting — not your body breaking. Three things can move the needle fast.

"My resting heart rate is ninety-five and I'm just sitting."

WHAT IT FEELS LIKE

You glance at your watch on a quiet afternoon and your resting heart rate is ninety-five. You are sitting on the couch. You are not anxious. You are not exercising. But your heart is. You google this at midnight. The internet is unhelpful. You panic mildly. The heart rate goes up.

WHAT IS ACTUALLY HAPPENING

Dehydration alone can raise resting heart rate by ten to fifteen beats per minute. Add electrolyte shifts, lower blood volume from rapid weight loss, and a sympathetic nervous system that has been doing different work than usual, and a higher resting rate is predictable. It can also be a real signal that something needs attention.

THREE THINGS TO TRY

- Drink water — really drink it — and add electrolytes once a day. Recheck the rate after a day of full hydration.
- Cut caffeine in half for a week and see. The shot makes caffeine hit harder.
- Slow your breath. Four seconds in, six seconds out, five minutes. This downshifts the autonomic system in real time.

ASK YOUR CLINICIAN

- Can we get an ECG to look at this baseline, especially if it is persistent?
- Is my dose at a level that may be amplifying autonomic effects?
- Are my electrolytes — particularly potassium and magnesium — in the right range?

CALL THE SAME DAY IF

- Heart rate over one-twenty at rest, persistently
- Heart racing with chest pain or pressure — call 911
- Heart racing with shortness of breath or fainting — call 911
- Heart racing with vision changes or one-sided weakness — call 911

And still — a calmer resting heart rate three months from now is one of the quiet wins of this drug. This week is loud. The trajectory is not.

CHAPTER

18 Muscle Loss And Soft Body

A known effect. A known mechanism. A known fix. You are not making this up.

"The scale is down but I look softer, not better."

WHAT IT FEELS LIKE

You step on the scale. The number is twenty pounds lower. You take off your robe and look in the mirror. You do not look twenty pounds better. You look smaller, but also softer. Less defined. The fat that left took some friends with it.

WHAT IS ACTUALLY HAPPENING

Without resistance training and adequate protein, twenty to forty percent of weight lost on a GLP-1 can come from lean muscle mass. Muscle is metabolically expensive. The body sheds what it does not use, especially when calorie intake is low and you are not asking the muscle to do anything. The scale goes down. The shape changes in the wrong direction.

THREE THINGS TO TRY

- Resistance training two to three times a week, non-negotiable. Compound movements — squats, deadlifts, push, pull. Heavier than you think.
- Hit your protein floor every single day. For most adults on a GLP-1, that is at least 0.7 grams per pound of goal body weight.
- Walk for steps but lift for shape. They are not the same intervention. Steps are not enough.

ASK YOUR CLINICIAN

- Can we measure body composition — not just weight — so we know what we are actually losing?
- Is my current rate of weight loss too fast to preserve muscle?
- Should we look at creatine or other supplements that support muscle preservation in my case?

CALL THE SAME DAY IF

- Muscle weakness severe enough to affect climbing stairs or standing from a chair
- Muscle pain with dark or rust-colored urine — call same-day
- Sudden severe one-sided weakness — call 911
- Falls or near-falls from leg weakness

And still — the fat you are losing is coming off. The muscle can be defended. Two of the three fixes above are things you were going to have to learn anyway. This drug just moved the deadline up.

CHAPTER

19 Mood Flattening

The drug is doing what it is supposed to do. This is the price of admission for month one or two. It softens.

"I lost the weight and I lost the joy with it."

WHAT IT FEELS LIKE

Your favorite song comes on and you do not feel it. The thing that used to make you laugh out loud gets a small smile. The first sip of coffee — gone, neutral. You are not depressed, exactly. The volume is just turned way down on everything.

WHAT IS ACTUALLY HAPPENING

The same receptors GLP-1 medications act on to quiet hunger also sit in the brain's reward and pleasure circuits. The dopamine response to food, music, sex, achievement — all of it — can flatten. For some people it is subtle. For others it is loud. It is real. It is pharmacology, not personality.

THREE THINGS TO TRY

- Schedule pleasure deliberately, even when it does not feel like it lands. The brain re-learns reward through repetition.
- Movement and sunlight every morning. Both nudge dopamine in ways that complement what the medication is suppressing.
- Connection in person beats connection through a screen — the dopamine response to real human contact is harder to flatten.

ASK YOUR CLINICIAN

- Could the dose be adjusted to reduce the dampening effect on my mood while keeping the metabolic benefit?
- What is the off-ramp plan if this flatness persists?
- Should we involve a psychiatrist or a therapist as part of this conversation?

CALL THE SAME DAY IF

- Persistent low mood that lasts more than two weeks
- Loss of interest in things that used to matter to you
- Thoughts of harming yourself — call 988 or go to the ER
- Inability to feel any pleasure at all — anhedonia is a clinical sign

CHAPTER

20 Rebound Hunger Off-Drug

Nothing about this is a red flag on its own. Try the three things. Most people are back to baseline in weeks.

"I stopped and the food noise came back louder than before."

WHAT IT FEELS LIKE

You did the thing. You lost the weight. You came off the shot. And within two weeks, the food noise came roaring back — louder than before you started. You think about food the way you used to. Plus interest. You did not sign up for this part.

WHAT IS ACTUALLY HAPPENING

GLP-1 receptors can up-regulate during treatment. When the drug is removed, the receptors are hungry for signal — and the signal they get from food is amplified. Hunger hormones rebound. Appetite, food noise, and cravings can all come back stronger than baseline for a period. This is the part nobody talks about clearly enough.

THREE THINGS TO TRY

- Taper, do not stop cold turkey if you can avoid it. Discuss the right step-down with your clinician.
- Front-load protein in the first weeks off. The fullness signal is going to have to do more of the work without the drug.
- Keep the structure that worked on the drug — meal timing, hydration, movement. Lifestyle does not become optional just because the drug came out.

ASK YOUR CLINICIAN

- What does my taper schedule look like, specifically?
- Is bridge support — a lower dose, a different medication, structured nutrition — appropriate?
- If the food noise stays this loud, what is the plan?

CALL THE SAME DAY IF

- Rebound eating that feels out of control — binge episodes
- Rapid weight regain — more than a few pounds a week
- Mood crash accompanying the rebound — call your clinician
- Thoughts of harming yourself — call 988 or go to the ER

CHAPTER

21 Vivid Dreams

This shows up in the trial data. Your clinician has seen it before. You can handle it — and this chapter shows you how.

"My dreams are weird, loud, and exhausting."

WHAT IT FEELS LIKE

You wake up at three a.m. mid-conversation with someone who has been dead for ten years. The dream felt like a movie. You can still describe the wallpaper in the imaginary room. You roll over and the next dream is just as loud.

WHAT IS ACTUALLY HAPPENING

GLP-1 medications can shift sleep architecture, particularly REM sleep. Add the metabolic changes underway and the autonomic shifts, and dream intensity often goes up. This is real. It is exhausting even if the dreams themselves are not nightmares.

THREE THINGS TO TRY

- Avoid screens for an hour before bed. Blue light plus already-disrupted REM is a bad combination.
- Keep the bedroom cool — 65 to 68 degrees. Cooler bedrooms produce deeper, less fragmented sleep.
- Consistent bed and wake times anchor the cycle. The body wants predictability when the chemistry is moving.

ASK YOUR CLINICIAN

- Could the dose timing be moved earlier in the day to reduce sleep disruption?
- Should we look at magnesium glycinate at bedtime for me?
- If this persists, is a sleep study appropriate?

CALL THE SAME DAY IF

- Night terrors or sleep paralysis that recur
- Acting out dreams physically — kicking, punching, falling out of bed
- Daytime function severely impaired by sleep loss
- Vivid dreams accompanied by a new mood crash

CHAPTER

22 Insomnia In The First Two Weeks

This is common. It has a name. It usually passes. Here is what to try tonight.

"I'm wired at midnight and exhausted at dawn."

WHAT IT FEELS LIKE

The first week or two on the shot — or the first week or two after a dose increase — you cannot sleep. Your body says down. Your brain says no. You stare at the ceiling. You stare at your phone. You stare at the inside of your eyelids. Morning comes anyway.

WHAT IS ACTUALLY HAPPENING

Your body is recalibrating. Cortisol rhythm shifts. Blood sugar regulation shifts. The drug is doing new work in old systems. The first two weeks are the loudest. After that, things usually settle. Usually.

THREE THINGS TO TRY

- Hold the line on sleep hygiene — same wake time every day, no matter what. Anchor the cycle.
- Avoid alcohol while titrating. It looks like a sleep aid. It is not.
- Magnesium glycinate at bedtime, with your clinician's nod. It is gentle, well-tolerated, and helps a lot of people.

ASK YOUR CLINICIAN

- Should we slow the titration if sleep is this disrupted?
- Is there a short-term sleep support option that is safe to use with this medication?
- When should I expect this to settle — and what do we do if it does not?

CALL THE SAME DAY IF

- No sleep at all for more than three nights
- Insomnia with racing thoughts, agitation, or a new low mood
- Insomnia with chest pain or palpitations
- Driving or working while severely sleep-deprived — stop and call

CHAPTER

23 Brain Fog And Forgetfulness

You are not alone in this. Most people on this drug hit some version of it. The fixes are simple.

"I walked into a room and forgot why three times today."

WHAT IT FEELS LIKE

You are mid-sentence and the word leaves the building. You walk into the kitchen and stand there, waiting for your brain to tell you why. You pay the same bill twice. You forget a name you have known for ten years. You worry, briefly, about something larger. It is the shot. Probably.

WHAT IS ACTUALLY HAPPENING

Lower calories plus altered cortisol plus changed sleep plus electrolyte shifts plus possible B12 and iron gaps add up to a foggier brain. The brain is metabolically expensive — it runs on twenty percent of your daily energy. Cut the input, and the processor slows.

THREE THINGS TO TRY

- Protein at breakfast. Twenty-five to thirty-five grams within an hour of waking.
- Get outside in the morning for ten minutes. Morning light sharpens cognition more than coffee does.
- Hydrate aggressively and add electrolytes. Mild dehydration is a brain-fog accelerant.

ASK YOUR CLINICIAN

- Can we check B12, ferritin, vitamin D, and a thyroid panel?
- Is my protein intake hitting the floor it needs to hit for cognition?
- Should we be slowing the rate of weight loss if the cognitive effect is this noticeable?

CALL THE SAME DAY IF

- Sudden severe confusion, slurred speech, or one-sided weakness — call 911
- Memory loss severe enough to affect daily function
- Fog with a new headache unlike any you have had — call same-day
- Disorientation about time, place, or people

And still — most people report their sharpest thinking of the year at month five or six, once eating is regular again. The fog is a fuel problem, not a brain problem.

CHAPTER

24 Anxiety Spikes After Injection

This is your body adjusting — not your body breaking. Three things can move the needle fast.

"I get a wave of dread in the twenty-four hours after my shot."

WHAT IT FEELS LIKE

Within a day of injection, a wave shows up — anxiety with no cause, dread with no source. You scan your life for the threat. There is no threat. The wave passes in a day or two. Then the next injection arrives and the wave does too.

WHAT IS ACTUALLY HAPPENING

Some people experience an autonomic and neuroendocrine response to the injection — cortisol, adrenaline, and inflammatory signals all moving in the first day or two. For a small minority, this shows up as anxiety rather than nausea or fatigue. The wiring is the same. The expression is just different.

THREE THINGS TO TRY

- Move injection day to a calm day — not a Sunday-night-into-Monday-morning if you can help it.
- Slow your breath when the wave lands. Four seconds in, six seconds out, ten minutes. Repeat as needed.
- Movement — a walk, light yoga, anything that moves blood. Stillness amplifies the wave.

ASK YOUR CLINICIAN

- Could the dose be lowered to reduce the post-injection wave?
- Is there a different GLP-1 we should consider that may be better tolerated?
- Should I be in conversation with a therapist or psychiatrist alongside this?

CALL THE SAME DAY IF

- Panic attacks that prevent you from functioning
- Thoughts of harming yourself — call 988 or go to the ER
- Anxiety with chest pain or shortness of breath — call 911 if cardiac cannot be ruled out
- Anxiety severe enough to require emergency support

CHAPTER

25 Dry Skin And Dull Skin

A known effect. A known mechanism. A known fix. You are not making this up.

"My face looks tired in a way moisturizer doesn't fix."

WHAT IT FEELS LIKE

You catch yourself in the bathroom mirror and your skin looks paper. Dull. Flat. The light does not bounce off your face the way it used to. Your moisturizer is doing its best. Your moisturizer is not the problem.

WHAT IS ACTUALLY HAPPENING

Rapid weight loss reduces facial fat, dehydration tightens the skin, and lower intake of fats and micronutrients reduces the building blocks the skin needs. The result is dryness, dullness, and a tired-looking surface that is downstream of what is happening inside.

THREE THINGS TO TRY

- Eat fat. Real fat. Olive oil, avocado, nuts, fatty fish. The skin needs it as building material.
- Hydrate from the inside. Half your body weight in ounces. Most people on the shot are quietly under-hydrated.
- Switch to a heavier moisturizer with ceramides for now. The skin barrier is doing more work than usual.

ASK YOUR CLINICIAN

- Could a basic nutrient panel — vitamin D, B12, omega-3s — help us see what is going on underneath?
- Is the rate of weight loss too fast for the skin to keep up?
- Should I see a dermatologist for a baseline if this persists?

CALL THE SAME DAY IF

- Skin changes with a new rash, blistering, or peeling
- Skin changes with itching severe enough to disrupt sleep
- Skin changes with yellow tint to the skin or eyes — call same-day
- Skin changes with new moles or lesions that look different from your others

CHAPTER

26 Brittle Nails

The drug is doing what it is supposed to do. This is the price of admission for month one or two. It softens.

"My nails crack and peel like paper."

WHAT IT FEELS LIKE

You file a nail and the whole tip comes off in layers. You catch a corner on a sweater and a split runs halfway down the nail bed. The nails grew before the shot. The nails are not growing the way they did before the shot.

WHAT IS ACTUALLY HAPPENING

Nails are protein. Specifically, keratin. When protein intake drops or stays low for months, the nails read the memo before most other tissues do. Iron, biotin, and zinc gaps amplify the signal.

THREE THINGS TO TRY

- Protein every meal, every day. There is no shortcut around this one. Nails are made of what you eat.
- Keep them short while they are fragile. Long brittle nails are just heartbreak waiting to happen.
- Strengthening base coats and avoidance of acetone removers for a few months — give the bed a chance to rebuild.

ASK YOUR CLINICIAN

- Can we check ferritin, B12, biotin, and zinc?
- Is my protein intake where it needs to be — what number should I aim for?
- Are there food-first sources you would prioritize for me?

CALL THE SAME DAY IF

- Nails turning blue, purple, or white at the base — circulation signal
- Spoon-shaped nails or visible deep ridges — possible iron deficiency
- Nails separating from the bed without trauma
- Nail changes accompanied by extreme fatigue or hair loss — full panel time

CHAPTER

27 Headaches

Nothing about this is a red flag on its own. Try the three things. Most people are back to baseline in weeks.

"I have a low headache most days."

WHAT IT FEELS LIKE

It is not a migraine. It is not a splitting pain. It is a low, gray pressure that sits behind your eyes most afternoons. You take ibuprofen. It helps a little. You drink water. It helps a little. It comes back tomorrow.

WHAT IS ACTUALLY HAPPENING

Dehydration plus low blood sugar plus changed sleep plus electrolyte shifts equals a steady, low-grade headache for many people on the shot. Tension from changed posture and clenched jaws while titrating piles on top. It is a stack, not a single cause.

THREE THINGS TO TRY

- Hydrate first. Half your body weight in ounces of water with at least one electrolyte add per day. Most low headaches resolve here.
- Eat small, regular meals — protein every three to four hours. Blood-sugar headaches are common when meals get skipped.
- Watch your jaw and shoulders during the day. Many people clench through nausea without noticing.

ASK YOUR CLINICIAN

- Are my electrolytes in the right zone — can we test?
- Should we look at my eating pattern for blood-sugar gaps?
- If this persists, when do we image or refer to a neurologist?

CALL THE SAME DAY IF

- Sudden severe headache unlike any you have had — call 911
- Headache with vision changes, slurred speech, or one-sided weakness — call 911
- Headache with fever and stiff neck — call 911
- Headache that wakes you from sleep regularly

CHAPTER

28 Restless Legs At Night

This shows up in the trial data. Your clinician has seen it before. You can handle it — and this chapter shows you how.

"My legs feel like I have to move them or jump out of my skin."

WHAT IT FEELS LIKE

You finally lie down. Your body says sleep. Your legs say absolutely not. There is a crawling, buzzing, has-to-move sensation that will not let you settle. You walk around the bedroom at 2 a.m. like a small ghost.

WHAT IS ACTUALLY HAPPENING

Restless legs syndrome and iron deficiency travel together. Lower iron intake, possible ferritin drop from rapid weight loss, and electrolyte shifts can light up the wiring that produces the creeping leg sensation. The shot is not directly causing it most of the time — it is exposing a gap that was already there.

THREE THINGS TO TRY

- Stretch the calves and hips deliberately before bed — five minutes, slow, with breath.
- Add magnesium glycinate at bedtime with your clinician's nod. It helps the muscle tissue and the nervous system at the same time.
- Cut caffeine after noon for two weeks. RLS feeds on stimulants.

ASK YOUR CLINICIAN

- Can we run a ferritin test — not just a hemoglobin, the actual ferritin?
- Should I be supplementing iron, and if so what form and dose?
- Are there medications I am on that could be making this worse?

CALL THE SAME DAY IF

- Restless legs severe enough to prevent sleep for many nights in a row
- Restless legs with numbness, weakness, or color changes
- Restless legs with new back pain — could be a nerve issue
- Sudden onset of severe symptoms

CHAPTER

29 Mood Swings And Irritability

This is common. It has a name. It usually passes. Here is what to try tonight.

"I snap at my husband over the toothpaste cap."

WHAT IT FEELS LIKE

The volume on your irritation is set higher than usual. Small things — the toothpaste cap, the dishwasher loaded wrong, the cashier who is too slow — register as personal attacks. You hear yourself say something sharp and you wonder where it came from.

WHAT IS ACTUALLY HAPPENING

Low calorie intake equals low blood sugar equals shorter fuse. Add disrupted sleep, shifted cortisol, and a brain that is doing different work than usual, and the irritability is downstream of biology, not character. It is real. It does not mean you are turning into someone else.

THREE THINGS TO TRY

- Eat. Even when you do not want to. Especially protein. Even when it is hard. The fuse rebuilds on fuel.
- Move every day. Movement is a mood regulator that works in real time.
- Tell your people what is happening. Not to excuse the snaps — to make them legible. Loved ones can hold a lot when they know what they are holding.

ASK YOUR CLINICIAN

- Could the dose be amplifying mood effects in a way we should adjust?
- Should we involve a therapist as part of this conversation?
- Are there labs — thyroid, ferritin, vitamin D, B12 — we should run?

CALL THE SAME DAY IF

- Rage that scares you or someone you love
- Mood swings with thoughts of harming yourself or someone else — call 988 or 911
- Persistent low mood lasting more than two weeks
- Hypomania or mania-like symptoms — sleep loss, grandiosity, impulsivity

CHAPTER

30 Stomach Cramping After Meals

You are not alone in this. Most people on this drug hit some version of it. The fixes are simple.

"Twenty minutes after I eat, my stomach grips like a fist."

WHAT IT FEELS LIKE

You eat. Twenty minutes later, a tight, gripping pain shows up in your upper abdomen. It comes in waves. It eases when you walk. It worsens when you sit hunched. You skip the next meal to avoid it. You should not skip the next meal.

WHAT IS ACTUALLY HAPPENING

Slow gastric emptying plus normal post-meal contractions can produce a cramping sensation as the stomach tries to push food through a system running at half speed. Trapped gas and food fermentation amplify it. For most people it is benign mechanics. For some it is the gallbladder or the pancreas signaling — which is why the call-same-day list matters.

THREE THINGS TO TRY

- Smaller meals, more often. Three to five small inputs beat one or two large ones.
- Walk for ten minutes after eating. Most post-meal cramps ease as the contents start to move.
- Sit upright, not slumped, for the hour after eating. Posture matters more than people think.

ASK YOUR CLINICIAN

- Should we image the gallbladder or check pancreatic enzymes if this pattern continues?
- Is my dose appropriate, or are we slowing things more than we should be?
- Are there foods worth eliminating for two weeks as a test?

CALL THE SAME DAY IF

- Severe pain that radiates to the back — possible pancreatitis, go to the ER
- Right-upper-quadrant pain with fever or vomiting — possible gallbladder, go to the ER
- Pain with yellowing of the skin or eyes — go to the ER
- Pain that does not resolve within a few hours and is severe

CHAPTER

31 Diarrhea

This is your body adjusting — not your body breaking. Three things can move the needle fast.

"Out of nowhere, I can't leave the bathroom."

WHAT IT FEELS LIKE

Most days you cannot go. Today, you cannot stop. The pattern flipped without warning. You cancel the lunch. You map every bathroom on the way home. You are not sure which version of this is worse.

WHAT IS ACTUALLY HAPPENING

Some people on GLP-1s skew constipation, some skew diarrhea, and some flip back and forth. Dose changes, gut microbiome shifts, and individual receptor distribution all play a role. Episodic diarrhea on the shot is common and usually self-limiting. Chronic diarrhea is not supposed to be the new normal.

THREE THINGS TO TRY

- Replace fluids and electrolytes aggressively — water alone is not enough when you are losing volume.
- Bland, low-fiber foods for a day or two — bananas, rice, applesauce, toast. The BRAT pattern still works.
- Identify and pull triggers — sugar alcohols, dairy, very high-fat meals. Reintroduce one at a time.

ASK YOUR CLINICIAN

- If this is recurrent, should we test for malabsorption or other gut issues?
- Is my dose contributing in a way we should adjust?
- Is there a stool test or workup that would clarify the cause?

CALL THE SAME DAY IF

- Diarrhea with blood — call same-day
- Diarrhea with high fever — call same-day
- Diarrhea with signs of severe dehydration — go to the ER
- Diarrhea lasting more than a few days without improvement

CHAPTER

32 Loss Of Appetite To The Point Of Forgetting To Eat

A known effect. A known mechanism. A known fix. You are not making this up.

"I looked at the clock and realized I hadn't eaten anything all day."

WHAT IT FEELS LIKE

Four p.m. arrives. You realize you have not eaten. Not because you were busy. Because the thought of food never crossed your mind. You eat a few crackers. They are fine. You forget again by tomorrow.

WHAT IS ACTUALLY HAPPENING

GLP-1s suppress appetite by design. For most people they reduce hunger to a manageable level. For a minority, especially at higher doses, they erase it entirely. Skipping meals on a calorie-suppressing drug is not weight-loss strategy — it is muscle loss, fatigue, and deficiency on a delay.

THREE THINGS TO TRY

- Set alarms. Eat by clock, not by hunger. Three to five small meals, every day, even when nothing sounds good.
- Front-load the day. Breakfast within an hour of waking, even if it is small. The earlier you start, the easier it gets.
- Liquid calories count — protein shakes, soups, smoothies. Use them as bridges when food does not appeal.

ASK YOUR CLINICIAN

- Is my dose too high if I am skipping meals entirely?
- Can we measure body composition to see whether we are losing muscle along with fat?
- Should we titrate down or pause to recalibrate?

CALL THE SAME DAY IF

- Sudden severe weakness, fainting, or confusion — signs of malnutrition or hypoglycemia
- Inability to eat anything for more than 48 hours
- Rapid, dramatic weight loss out of proportion to what we planned
- Hair loss, dizziness, and fatigue together — call same-day

CHAPTER

33 Dehydration

The drug is doing what it is supposed to do. This is the price of admission for month one or two. It softens.

"Dry mouth, dark urine, dizzy when I stand — I never feel thirsty anymore."

WHAT IT FEELS LIKE

You realize halfway through the day that you have not had any water. Not because you do not have access — you have a glass right there. Because the thirst signal has gone quiet. Then the consequences land: headache, dry mouth, dark urine, that small dizziness when you stand.

WHAT IS ACTUALLY HAPPENING

GLP-1s seem to quiet the thirst signal in some people the same way they quiet the hunger signal. Add the gastrointestinal losses — diarrhea or vomiting if either is part of your picture — and dehydration is the silent default on these drugs.

THREE THINGS TO TRY

- Drink by schedule, not by thirst. Half your body weight in ounces of water per day. A bottle by every room you live in.
- Add electrolytes daily. Sodium, potassium, magnesium. Most powders work fine if they are not full of sugar.
- Check your urine. Pale yellow is the target. Dark yellow means catch up. Clear all day every day means you are over-doing it.

ASK YOUR CLINICIAN

- Should we run a basic metabolic panel to look at electrolytes and kidney function?
- Is there a specific electrolyte formula you would recommend in my case?
- Are any of my other medications affected by hydration changes?

CALL THE SAME DAY IF

- Confusion, severe dizziness, or fainting — go to the ER
- No urination for more than twelve hours
- Rapid heart rate at rest along with the symptoms
- Severe vomiting or diarrhea with the dehydration — go to the ER

CHAPTER

34 Belching Air

Nothing about this is a red flag on its own. Try the three things. Most people are back to baseline in weeks.

"I burp constantly — not sulfur burps, just air."

WHAT IT FEELS LIKE

It is not the rotten-egg burps. It is just air. Constant, loud, unprovoked air. You burp mid-sentence. You burp watching TV. You apologize twelve times a day. People think you are doing it for attention. You are not.

WHAT IS ACTUALLY HAPPENING

A slowed stomach traps swallowed air. The air has nowhere to go except back the way it came. Add carbonation, fast eating, and chewing gum to the mix and the volume goes up. This one is annoying but almost always benign.

THREE THINGS TO TRY

- Eat slowly. Chew completely. Put the fork down between bites. You will swallow less air.
- Skip carbonation, straws, and gum for two weeks and see. All three add air without giving you any.
- Simethicone — Gas-X — helps a lot of people in the moment. Worth keeping in the bag.

ASK YOUR CLINICIAN

- Is there a digestive enzyme that would be appropriate for me to try?
- Could this be reflux presenting as burping — is a workup appropriate?
- If this is severe, should we reconsider the dose?

CALL THE SAME DAY IF

- Burping with chest pain or pressure — never assume burping is not cardiac
- Burping with vomiting blood or coffee-ground material
- Burping with severe upper abdominal pain
- Burping with weight loss that is out of control

CHAPTER

35 Loss Of Food Pleasure

This shows up in the trial data. Your clinician has seen it before. You can handle it — and this chapter shows you how.

"I'm eating to fuel, not to enjoy. I miss it."

WHAT IT FEELS LIKE

Sunday brunch used to be the highlight of the week. Now it is a thing you sit through. The first bite of a really good meal used to land. Now it registers as: bite, swallow, next. The shot took the weight. It also took something else.

WHAT IS ACTUALLY HAPPENING

The reward response to food is muted by GLP-1 medications. This is a feature, not a bug — it is part of how the drug works. The dopamine spike that food used to produce is smaller. For some people that is fine. For others, food was where the joy lived, and the loss is real.

THREE THINGS TO TRY

- Lean into the foods that still register. Texture, temperature, and aroma matter more now than they used to.
- Make eating social. The dopamine response to shared meals is partly social — that channel still works.
- Be honest about what you are losing. The grief is real. Some people decide the trade is worth it. Some decide it is not. Both are valid.

ASK YOUR CLINICIAN

- Could the dose be adjusted to soften this effect while keeping the metabolic benefit?
- Is this dose level the right one for me, or are we overshooting?
- What is the off-ramp plan if this loss of pleasure stays?

CALL THE SAME DAY IF

- Loss of pleasure that extends beyond food — to music, sex, work, friendship
- Persistent flat mood lasting more than two weeks
- Thoughts of harming yourself — call 988 or go to the ER
- Eating that drops below a sustainable floor

And still — the food that stopped bringing you joy was also the food that was hurting you. Some of the pleasure will come back. The rest, you will build somewhere else, on purpose.

CHAPTER

36 Weakness When You Don'T Eat Enough

This is common. It has a name. It usually passes. Here is what to try tonight.

"I'm dizzy at three p.m. because I forgot lunch."

WHAT IT FEELS LIKE

You did fine through the morning. You skipped lunch because nothing sounded good and you were busy. Three p.m. arrives and the room moves a little. You sit down. You feel hollow. You eat a granola bar. You feel better in twenty minutes. You promise yourself you will not skip tomorrow. You skip tomorrow.

WHAT IS ACTUALLY HAPPENING

Skipping meals on an appetite-suppressing drug is a recipe for hypoglycemia, electrolyte depletion, and muscle catabolism. The shot does not care that you forgot. The body still needs the fuel. When the fuel does not come in, the body finds it somewhere — and that somewhere is usually muscle.

THREE THINGS TO TRY

- Eat by clock, not by hunger. Three to five small meals a day, every day, alarms if necessary.
- Front-load protein at breakfast and lunch. Twenty-five to thirty-five grams each. The afternoon crash is downstream of the morning intake.
- Keep emergency food on you — a protein bar, mixed nuts, a small shake. The shot makes skipping cheap until it is not.

ASK YOUR CLINICIAN

- What is my real protein floor each day — what number do I need to hit?
- If skipping meals is happening this often, is the dose too high for me?
- Should we look at body composition, not just weight, to track what we are actually losing?

CALL THE SAME DAY IF

- Fainting or near-fainting
- Confusion, slurred speech, or severe weakness — call 911 if sudden
- Heart racing, sweating, shakiness — possible hypoglycemia
- Inability to eat enough to maintain function — call your clinician

THE LIBRARY

Keep going.

Three more field guides for the parts this book did not cover — plus the free companion questions.

EAT ANYWAY

The protein floor when food does not appeal. Five small meals, six high-density foods, and the fix for the burp-nausea reflex that keeps you from finishing the plate.

https://www.marenwhitlock.com/eat-anyway · $14.99

FEEL IT AGAIN

The cortisol reset for the shot-induced energy crash. Morning protocol, sleep architecture, and the supplements that actually move the needle — not the ones on TikTok.

https://www.marenwhitlock.com/feel-it-again · $14.99

MOVE TO KEEP IT

The 25-minute, three-times-a-week lift template that keeps your metabolism warm while you lose weight. The workout that defends what you are trying to keep.

https://www.marenwhitlock.com/move-to-keep-it · $14.99

THE FULL BUNDLE

Eat Anyway + Feel It Again + Move To Keep It. The complete companion to this book — the eating, the energy, and the lifting, all in one download.

https://www.marenwhitlock.com/glp1-bundle · All three guides · one price

THE BRAIN 5 · FREE

Five questions to bring to your next appointment about the mood, motivation, and pleasure changes the shot can cause. The exact words to use with your clinician — free.

Reply with the word BRAIN to receive it.

THE LAST PAGE

The Wins Are Still Real.

Every side road in this book is real. And also — the reason you started this drug is real. The food noise is quieter. The stairs are easier. The seatbelt fits. Your labs are moving. You are sleeping. You caught your reflection in a window last week and did not look away.

None of that is nothing. None of that is erased by a rough eight weeks of adjustment. Both things are true at once, and that is allowed.

The women who do best on this drug are not the ones who had zero side effects. They are the ones who knew what was coming, tried the three fixes, and called their clinician on the two things that needed a call. That is you now.

You are not crazy. It is the shot. And you are going to be okay.

> If this guide helped you, send it to one person who has been quietly asking herself what is wrong with me. That one share is how she finds this.

— Maren

Before You Inject