

# daily health journal



## Today's Conditions and Symptoms

Check the areas which apply to your condition. Be as thorough as possible.

- Ears/Eyes/Nose
- Mouth/Throat
- Head/Neck/Back
- Shoulders/Arms/Hands
- Hips/Legs/Feet
- Chest/Heart
- Respiratory
- Digestive
- Skin

Date \_\_\_\_\_ Day \_\_\_\_\_

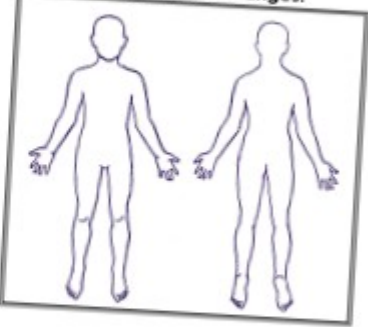
### Today's Weather:

- Hot
- Sunny
- Damp
- Warm
- Overcast
- Rainy
- Cool
- Cloudy
- Snowy
- Cold
- Foggy
- Windy

### Medications/Supplements:

Name	Quantity	Time

### Pain/Discomfort/Skin Changes:



	AM	PM
Weight		
Temp		
Hours Slept Last Night	# of hours:	Sound
	How many?	Restless
Naps taken today	Total Hours:	

### Physical Activity:

Activity	Hours	Minutes

### Measurements:

Chest		R. Thigh	
Waist		R. Bicep	
Hip		R. Calf	

### Scale:

1. Mild
2. Moderate
3. Severe
4. Very Severe
5. Worst Possible

Mark the area where the pain occurs with the number that corresponds to the intensity of the pain.

### Overall today, I felt:

- Good
- Fair
- Poor

