daily health journal

Date Day

Today's Weather:

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

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

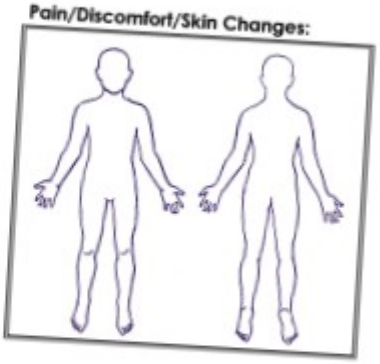
Medications/Supplements:

Name	Quantity	Time

Physical Activity:

Activity	Hours	Minutes

Pain/Discomfort/Skin Changes:



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

peonies & poppyseeds