

# 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/Neck

☐ Hips/Legs/Feet

☐ Chest/Heart

☐ Respiratory

☐ Digestive

☐ Skin

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

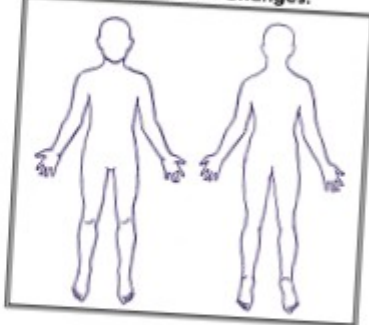
### Today's Weather:

- |                               |                                   |                                |
|-------------------------------|-----------------------------------|--------------------------------|
| <input type="checkbox"/> Hot  | <input type="checkbox"/> Sunny    | <input type="checkbox"/> Damp  |
| <input type="checkbox"/> Warm | <input type="checkbox"/> Overcast | <input type="checkbox"/> Rainy |
| <input type="checkbox"/> Cool | <input type="checkbox"/> Cloudy   | <input type="checkbox"/> Snowy |
| <input type="checkbox"/> Cold | <input type="checkbox"/> Foggy    | <input type="checkbox"/> Windy |

### Medications/Supplements:

Name	Quantity	Time

### Pain/Discomfort/Skin Changes:



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

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