



# **MY LIFE & BREATH**

## **THE SARCOIDOSIS PLANNER**

HOPE & EMPOWERMENT

Life & Breath Foundation  
[lifeandbreath.org](http://lifeandbreath.org)

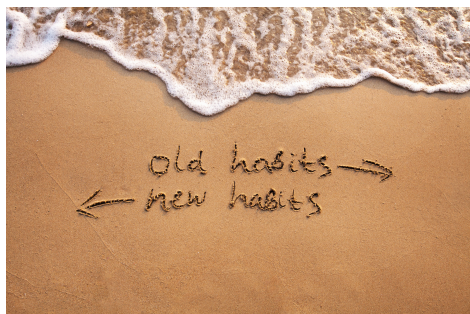


# TRACKING HABITS, SYMPTOMS, AND MEDICATIONS

This section is designed to assist you in tracking your habits and symptoms. Each page can be duplicated as needed. It could be helpful for you to bring the monthly summary sheet to your doctor appointments to show the doctor a bird's eye overview of your health.

“

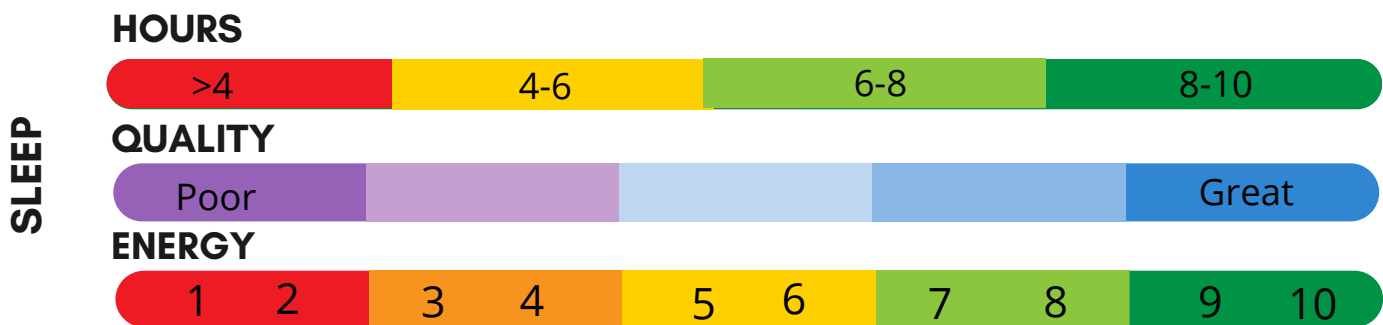
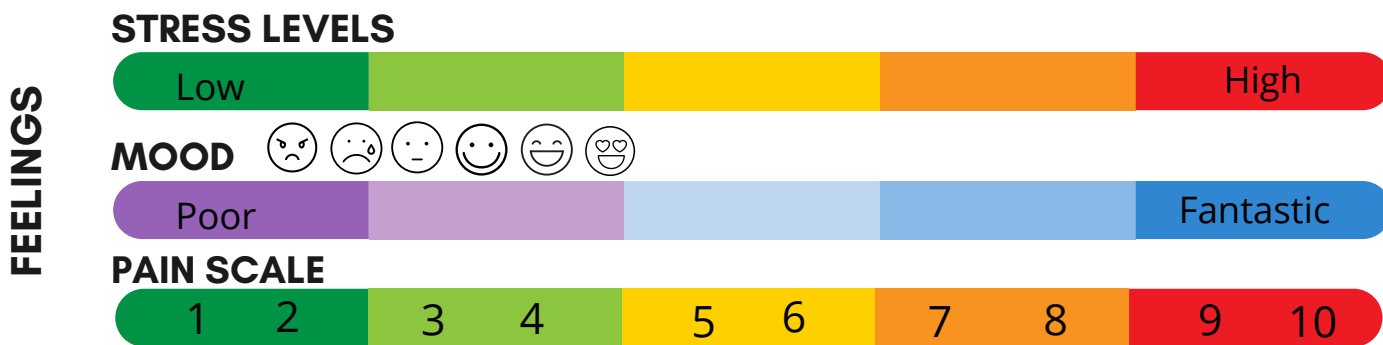
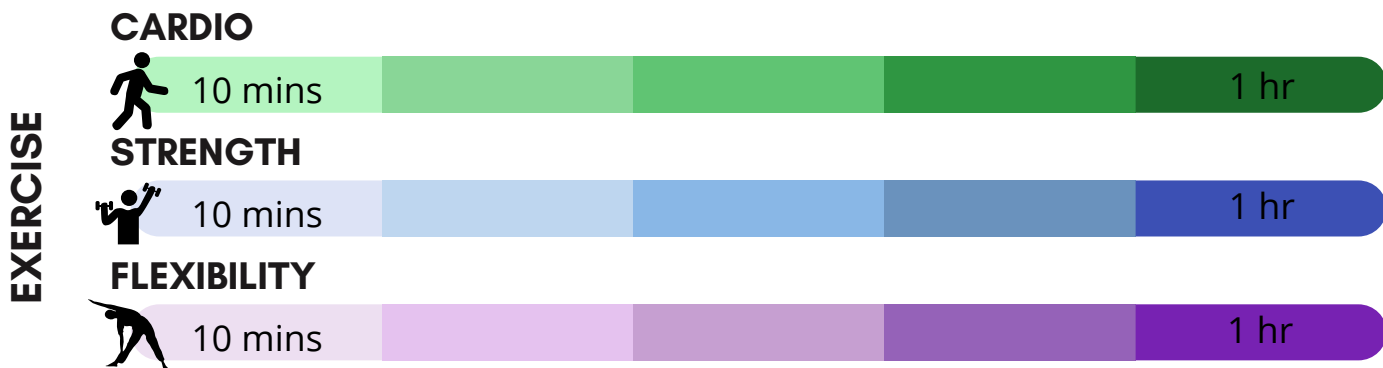
*The secret to being happy is accepting where you are in life, and making the most of every day.* UNKNOWN



	Breakfast Time :	Lunch	Dinner	Snacks
<b>FOOD</b>				

**WATER**

**COFFEE/TEA**



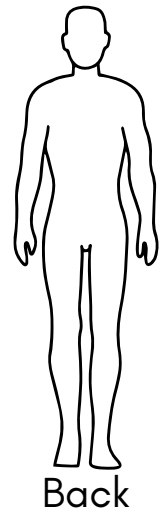
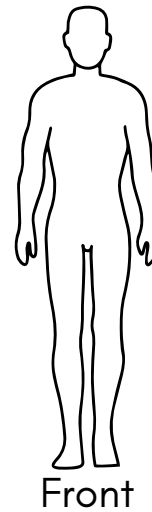
**OTHER**

Meditation    Journaling    Smoking: # \_\_\_\_    Alcohol: \_\_\_\_ oz.

Weight \_\_\_\_\_    Recreational Drugs    Pain Meds \_\_\_\_\_

Additional Medications used support	Time	Dose

Symptom Description	AM	PM

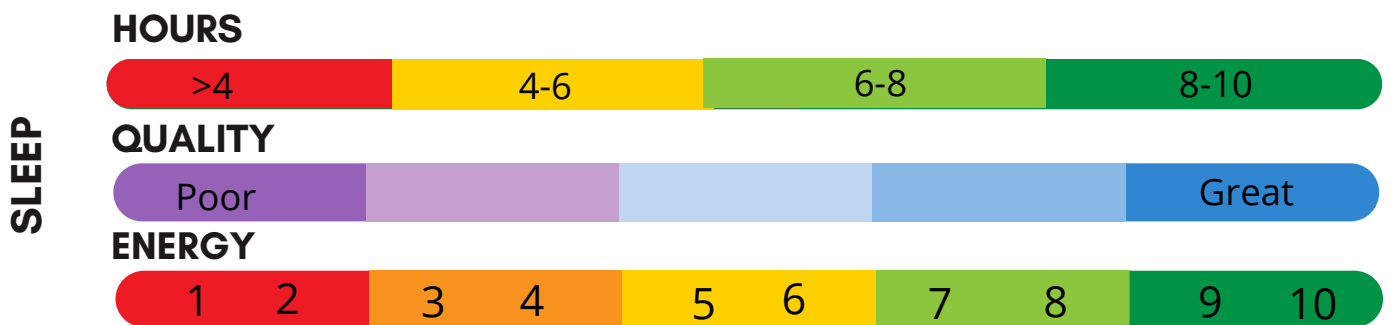
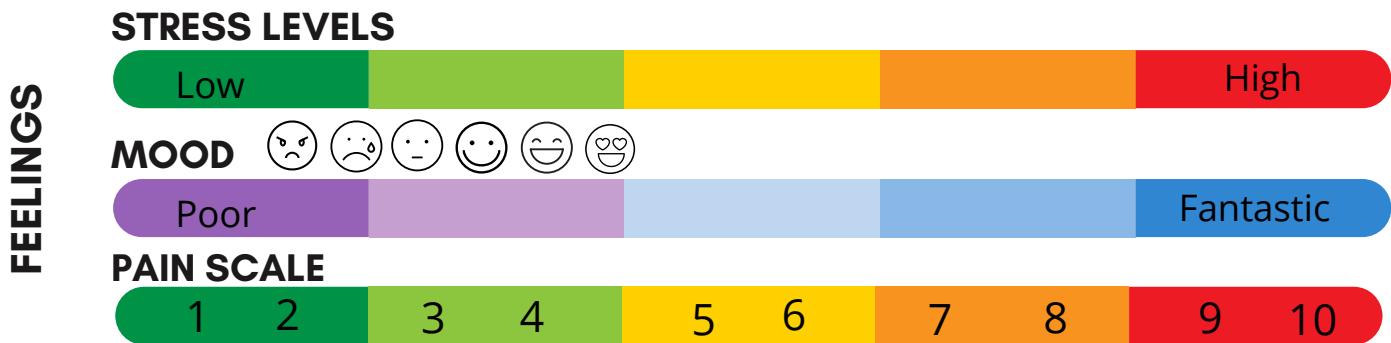
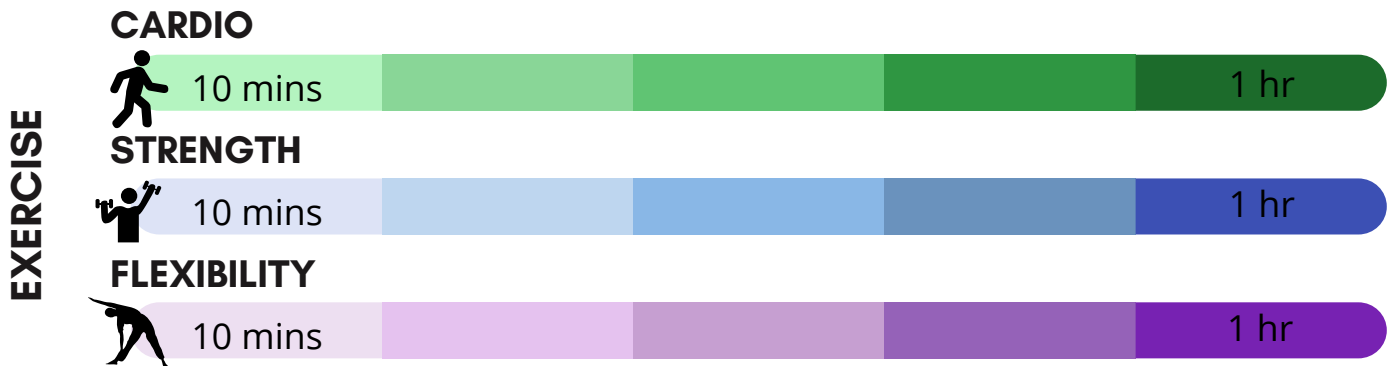
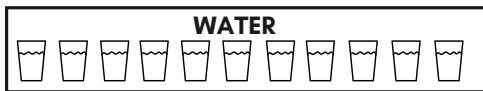


**OTHER SYMPTOMS**

- |                                   |                                     |                                       |                                      |
|-----------------------------------|-------------------------------------|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> Anger    | <input type="checkbox"/> Depression | <input type="checkbox"/> Fatigue      | <input type="checkbox"/> Lethargy    |
| <input type="checkbox"/> Anxiety  | <input type="checkbox"/> Diarrhea   | <input type="checkbox"/> Fever        | <input type="checkbox"/> Nausea      |
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**NOTES:**

	Breakfast Time :	Lunch	Dinner	Snacks
<b>FOOD</b>				



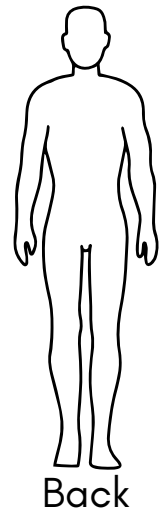
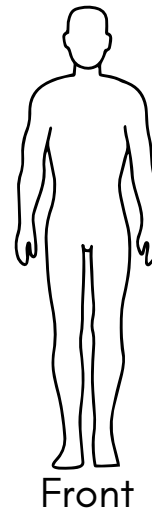
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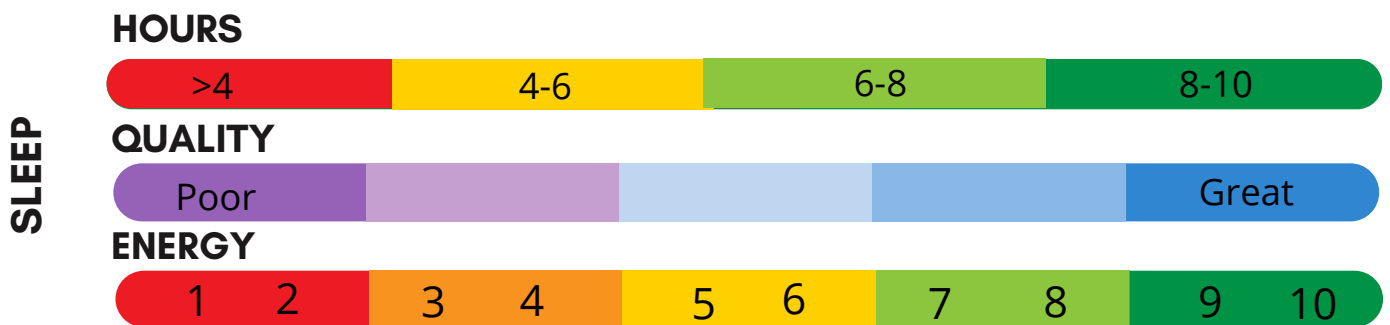
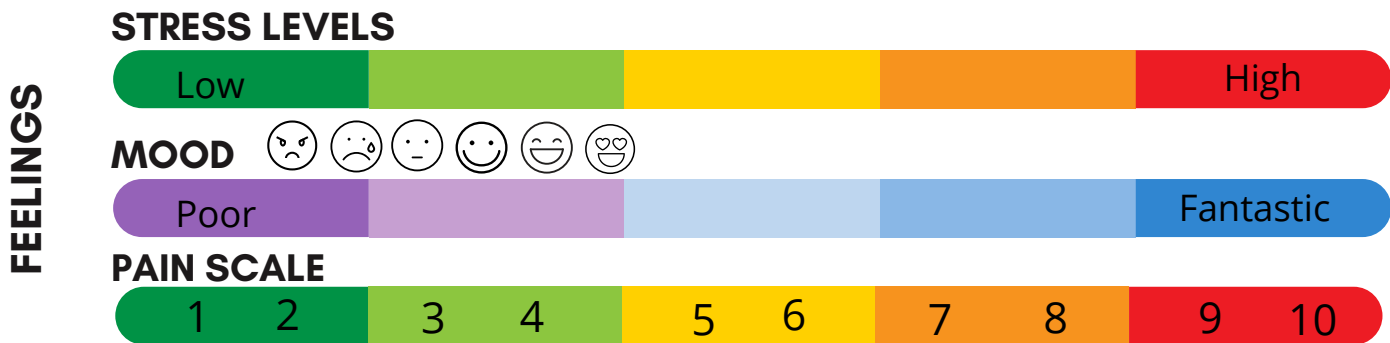
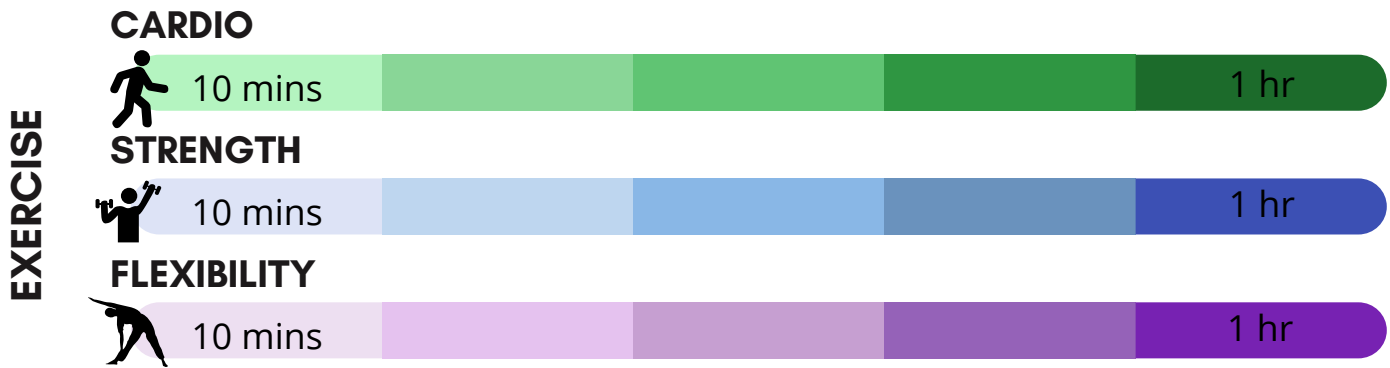
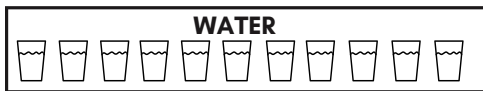


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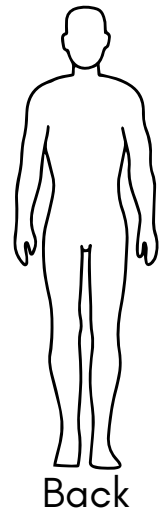
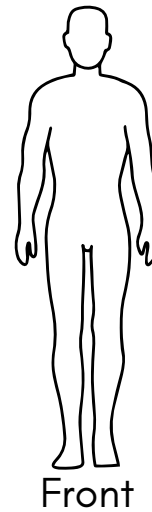
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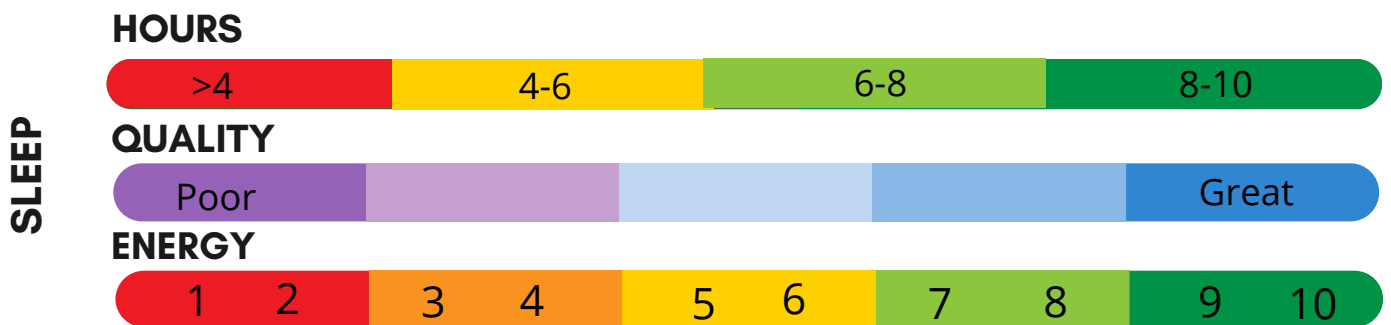
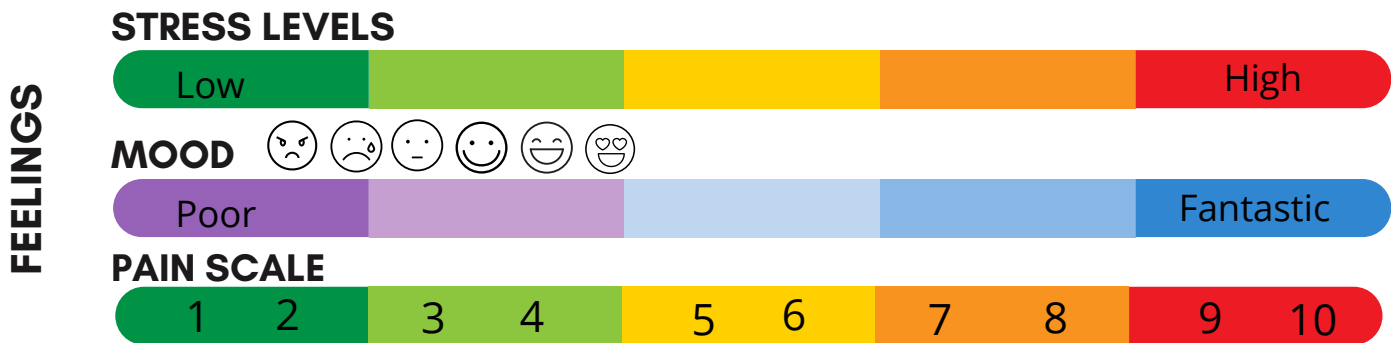
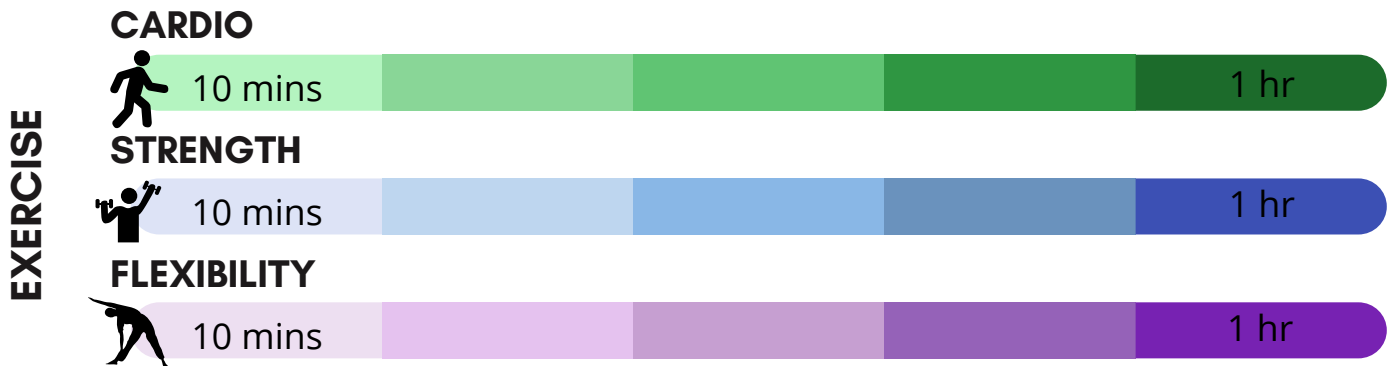
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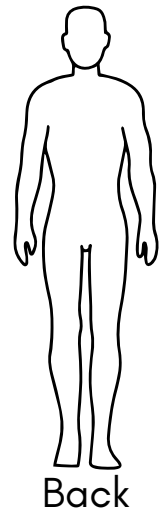
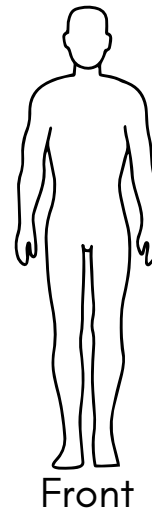
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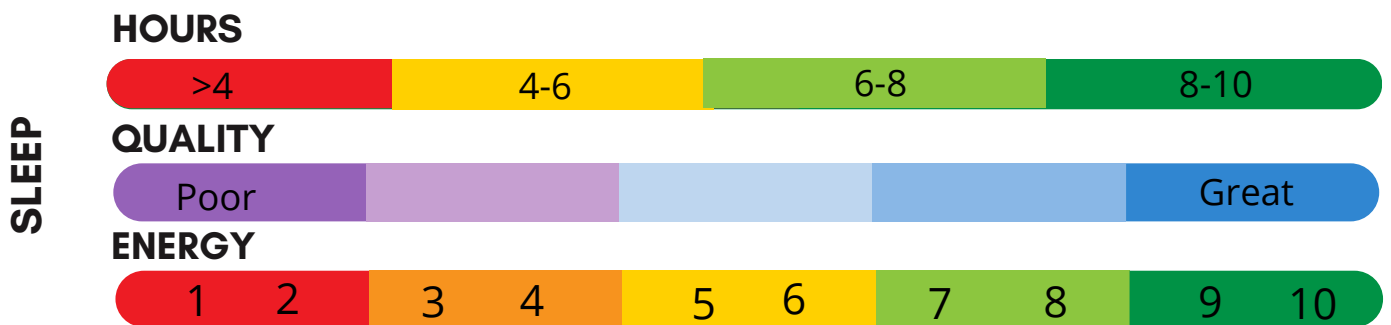
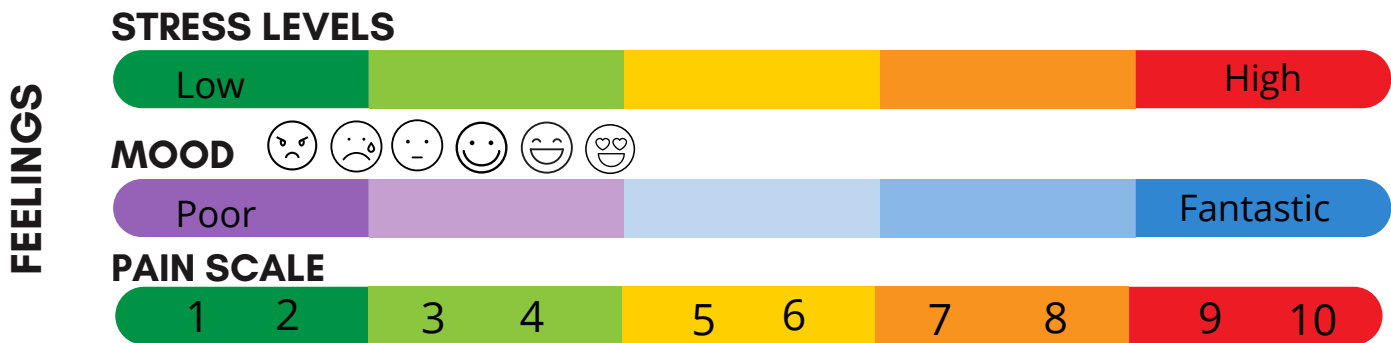
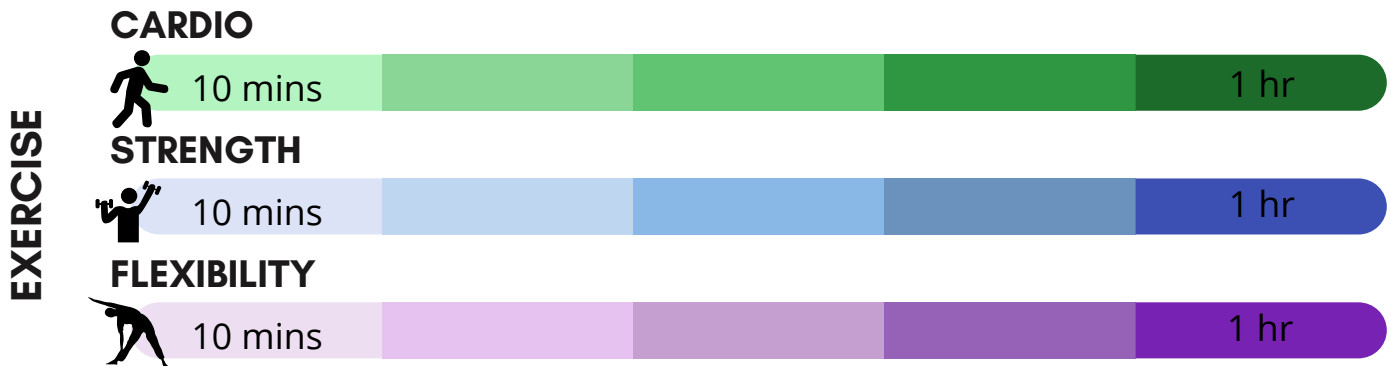
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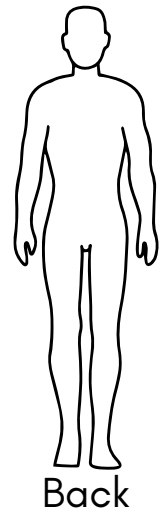
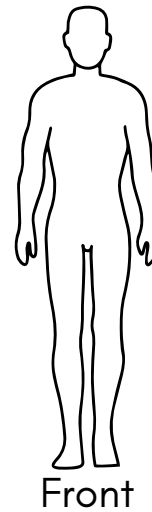
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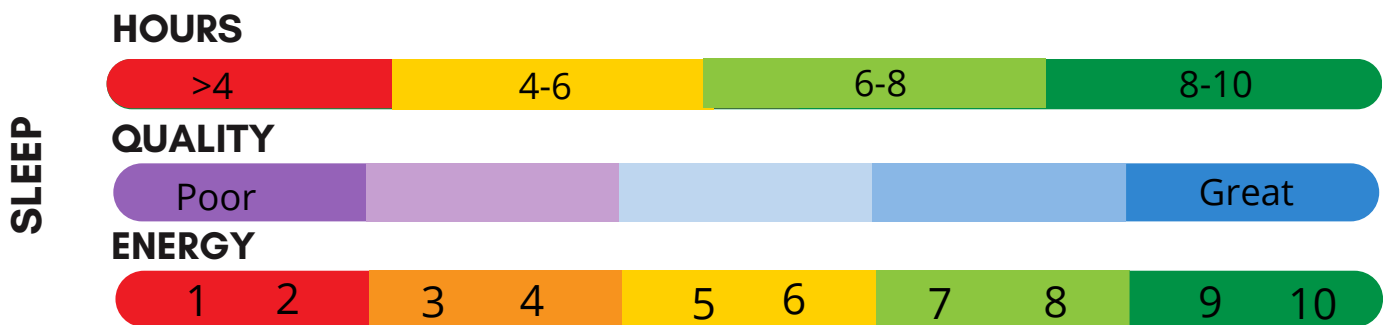
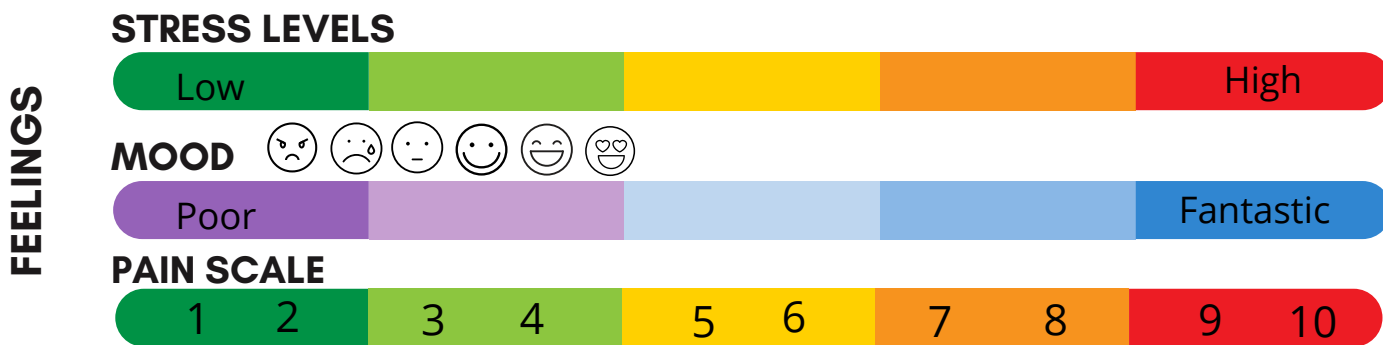
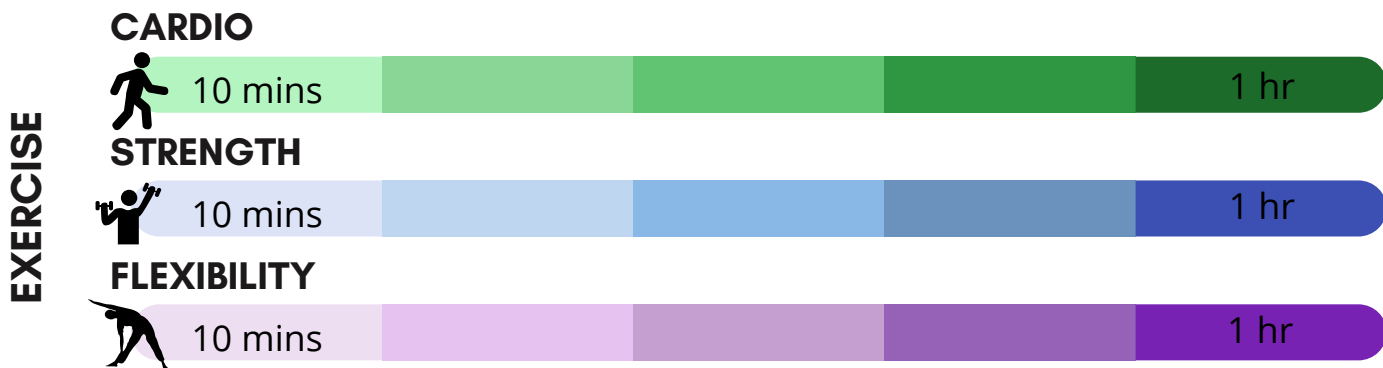
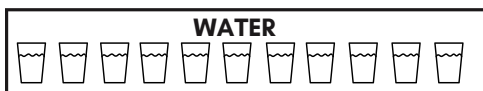


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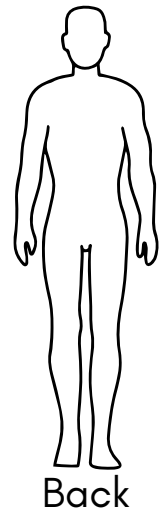
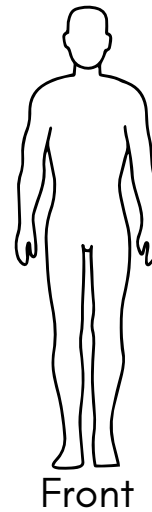
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**NOTES:**

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FOOD				

**WATER**

**COFFEE/TEA**

**EXERCISE**

**CARDIO** 10 mins 1 hr

**STRENGTH** 10 mins 1 hr

**FLEXIBILITY** 10 mins 1 hr

**FEELINGS**

**STRESS LEVELS** Low High

**MOOD** Poor Fantastic

**PAIN SCALE** 1 2 3 4 5 6 7 8 9 10

**SLEEP**

**HOURS** >4 4-6 6-8 8-10

**QUALITY** Poor Great

**ENERGY** 1 2 3 4 5 6 7 8 9 10

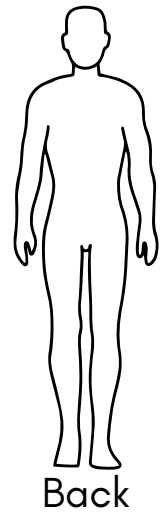
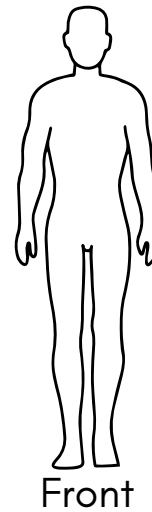
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Additional Medications used support	Time	Dose

Symptom Description	AM	PM



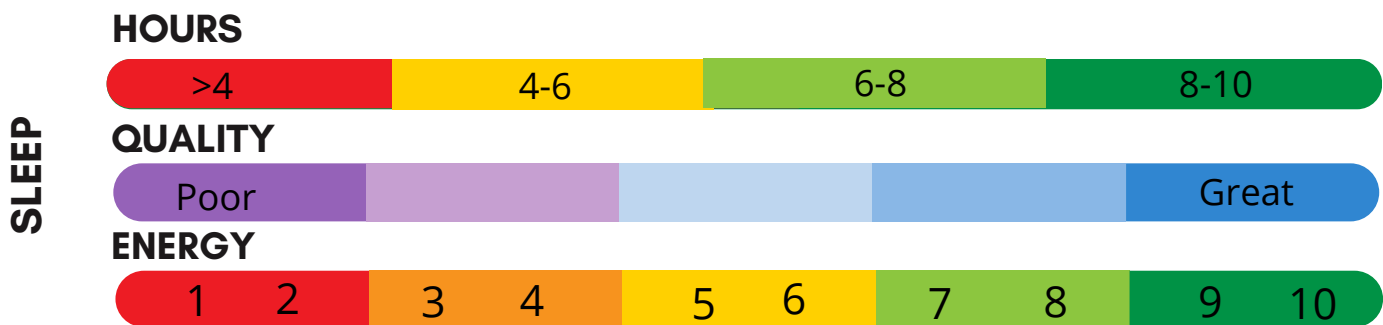
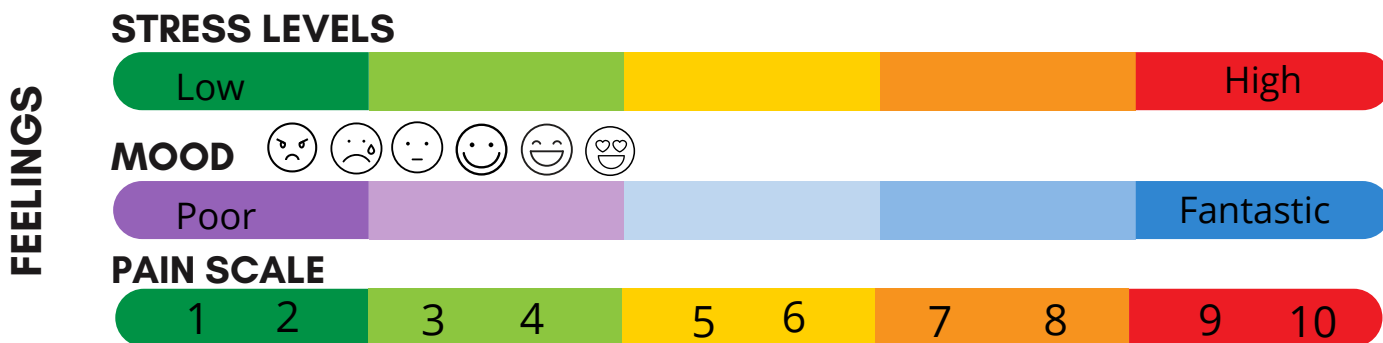
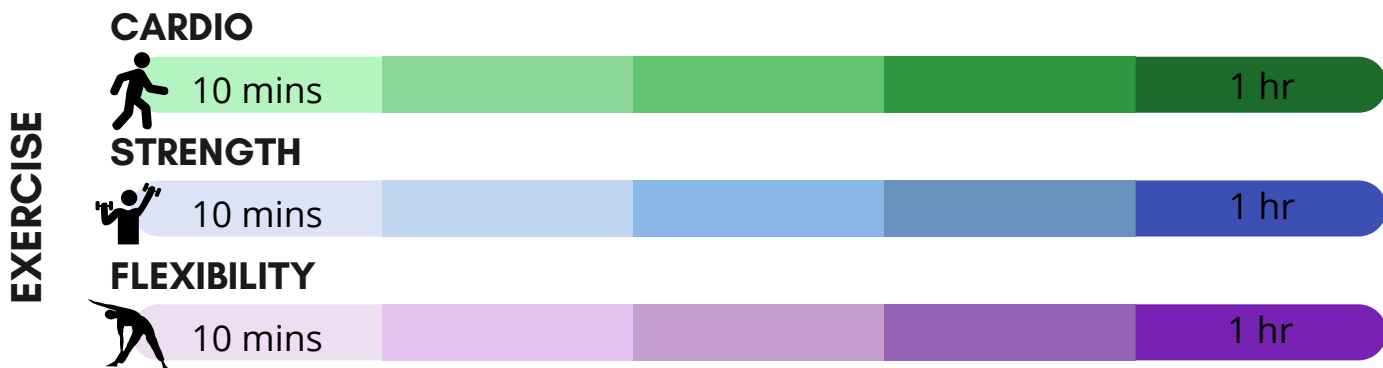
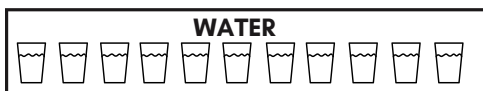
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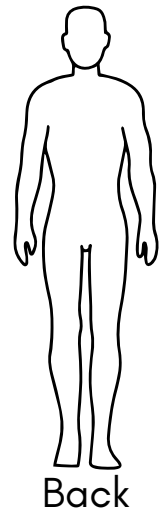
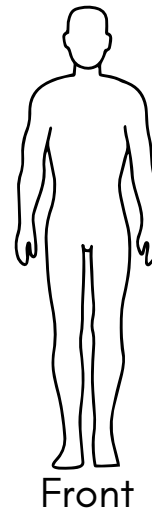
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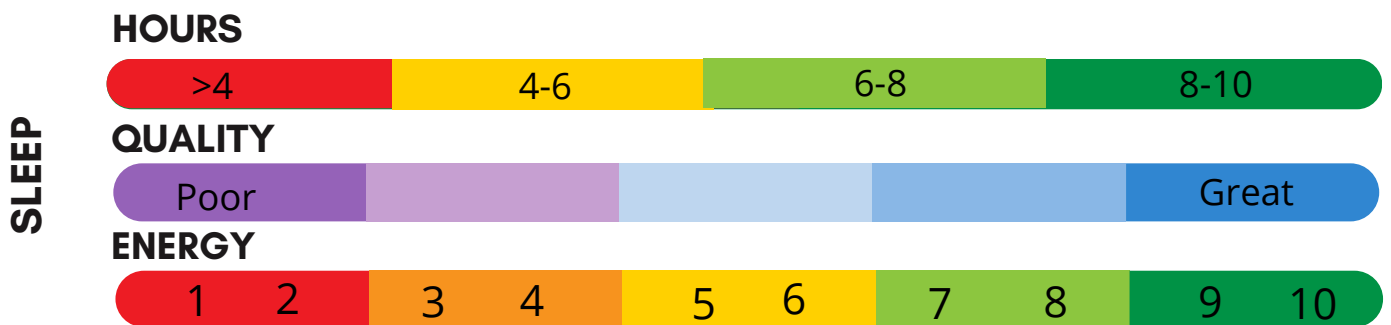
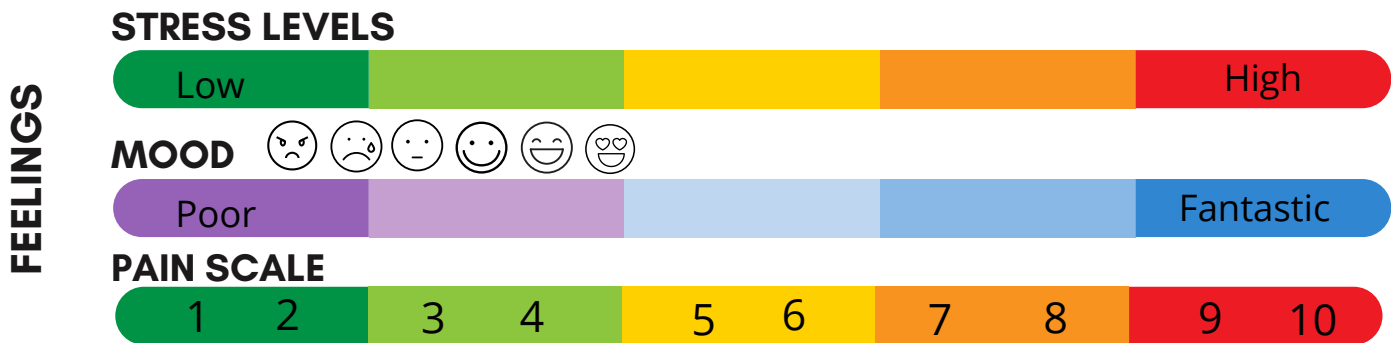
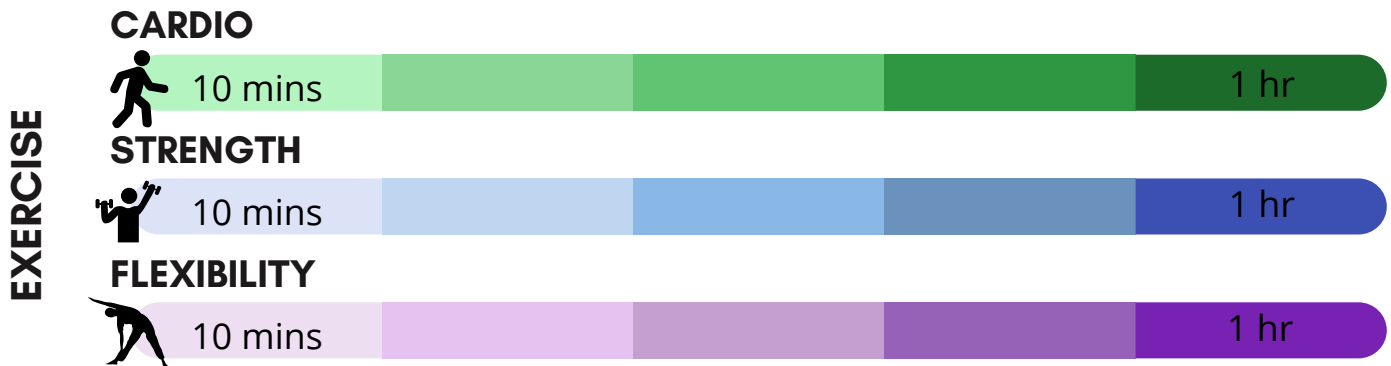


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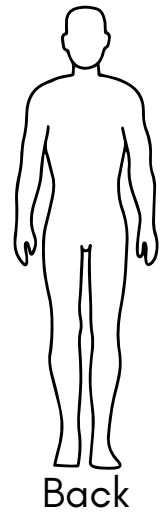
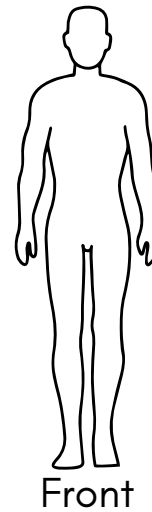
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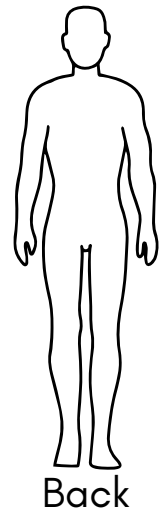
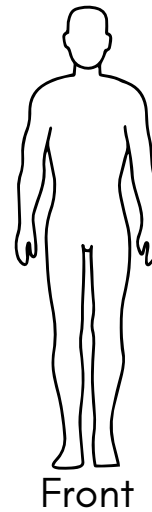
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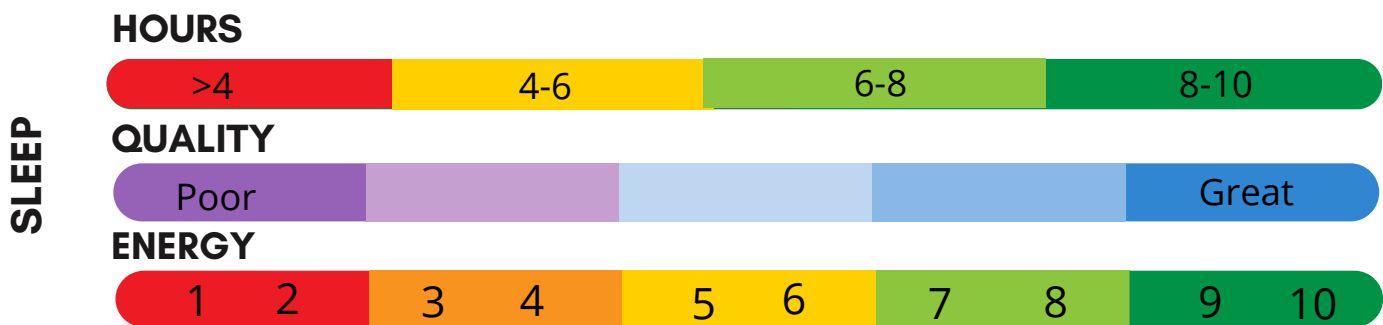
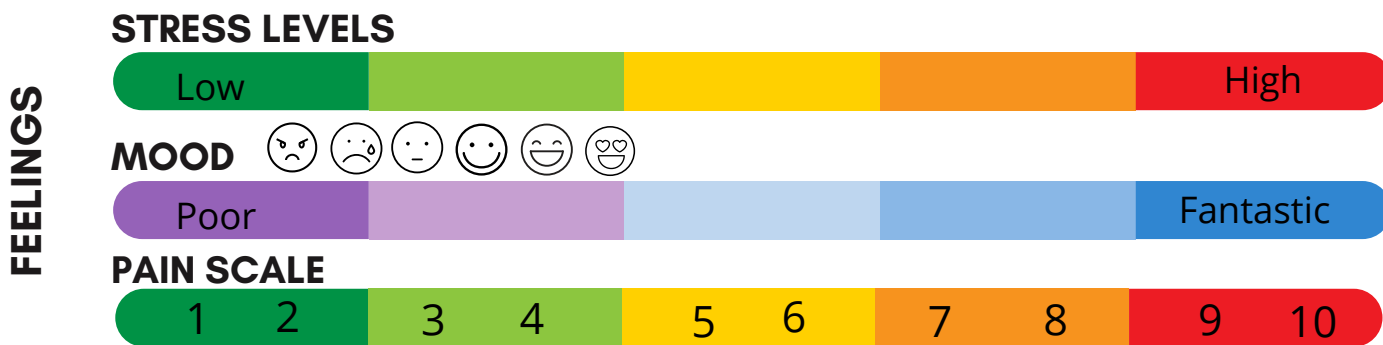
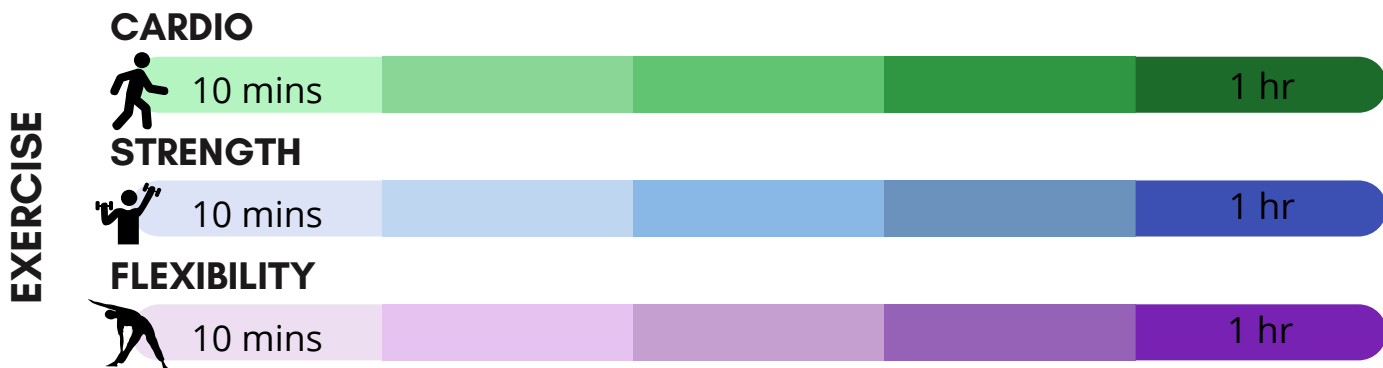
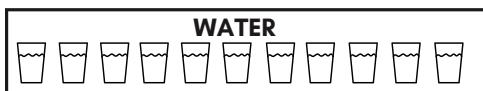


**OTHER SYMPTOMS**

- |                                   |                                     |                                       |                                      |
|-----------------------------------|-------------------------------------|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> Anger    | <input type="checkbox"/> Depression | <input type="checkbox"/> Fatigue      | <input type="checkbox"/> Lethargy    |
| <input type="checkbox"/> Anxiety  | <input type="checkbox"/> Diarrhea   | <input type="checkbox"/> Fever        | <input type="checkbox"/> Nausea      |
| <input type="checkbox"/> Bloating | <input type="checkbox"/> Congestion | <input type="checkbox"/> Irritability | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> Chills   | <input type="checkbox"/> Exhaustion | <input type="checkbox"/> Insomnia     | <input type="checkbox"/> Vomiting    |
| <input type="checkbox"/> _____    | <input type="checkbox"/> _____      | <input type="checkbox"/> _____        | <input type="checkbox"/> _____       |

**NOTES:**

	Breakfast Time :	Lunch	Dinner	Snacks
FOOD				



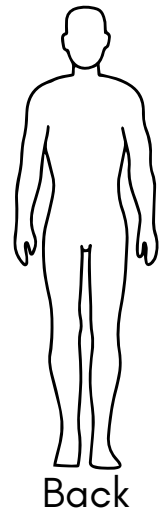
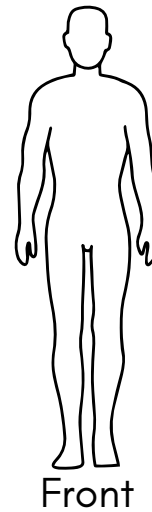
**OTHER**

Meditation    Journaling    Smoking: # \_\_\_\_    Alcohol: \_\_\_\_ oz.

Weight \_\_\_\_\_    Recreational Drugs    Pain Meds \_\_\_\_\_

Additional Medications used support	Time	Dose

Symptom Description	AM	PM



**OTHER SYMPTOMS**

- |                                   |                                     |                                       |                                      |
|-----------------------------------|-------------------------------------|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> Anger    | <input type="checkbox"/> Depression | <input type="checkbox"/> Fatigue      | <input type="checkbox"/> Lethargy    |
| <input type="checkbox"/> Anxiety  | <input type="checkbox"/> Diarrhea   | <input type="checkbox"/> Fever        | <input type="checkbox"/> Nausea      |
| <input type="checkbox"/> Bloating | <input type="checkbox"/> Congestion | <input type="checkbox"/> Irritability | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> Chills   | <input type="checkbox"/> Exhaustion | <input type="checkbox"/> Insomnia     | <input type="checkbox"/> Vomiting    |
| <input type="checkbox"/> _____    | <input type="checkbox"/> _____      | <input type="checkbox"/> _____        | <input type="checkbox"/> _____       |

**NOTES:**



	Breakfast Time :	Lunch	Dinner	Snacks
FOOD				

**WATER**

**COFFEE/TEA**

**EXERCISE**

**CARDIO** 10 mins 1 hr

**STRENGTH** 10 mins 1 hr

**FLEXIBILITY** 10 mins 1 hr

**FEELINGS**

**STRESS LEVELS** Low High

**MOOD** Poor Fantastic

**PAIN SCALE** 1 2 3 4 5 6 7 8 9 10

**SLEEP**

**HOURS** >4 4-6 6-8 8-10

**QUALITY** Poor Great

**ENERGY** 1 2 3 4 5 6 7 8 9 10

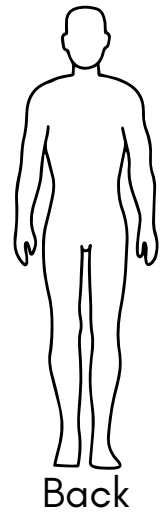
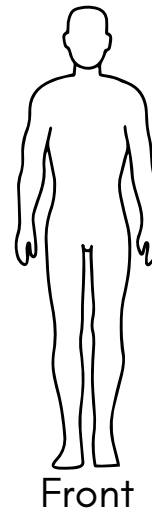
**OTHER**

Meditation    Journaling    Smoking: # \_\_\_\_    Alcohol: \_\_\_\_ oz.

Weight \_\_\_\_\_    Recreational Drugs    Pain Meds \_\_\_\_\_

Additional Medications used support	Time	Dose

Symptom Description	AM	PM

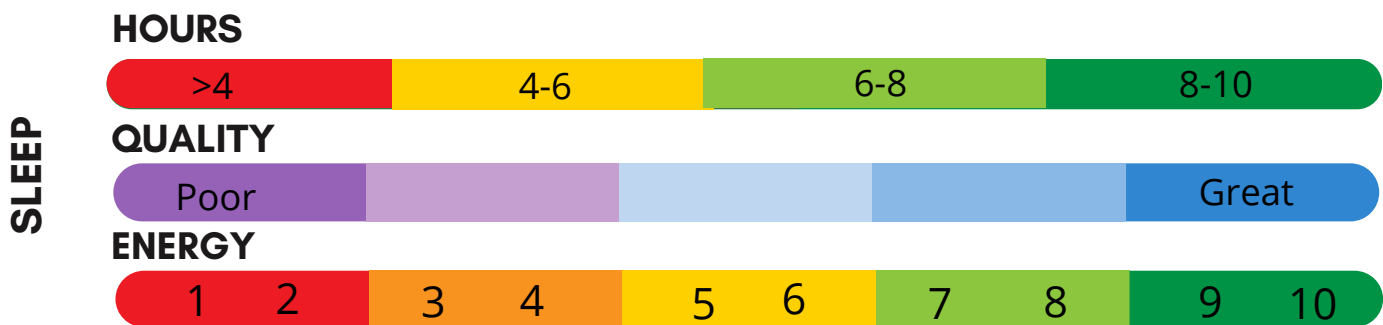
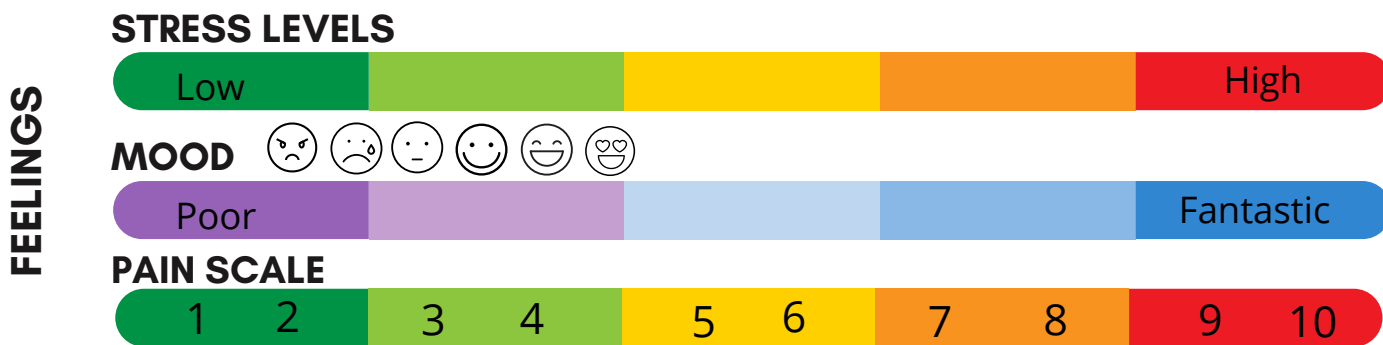
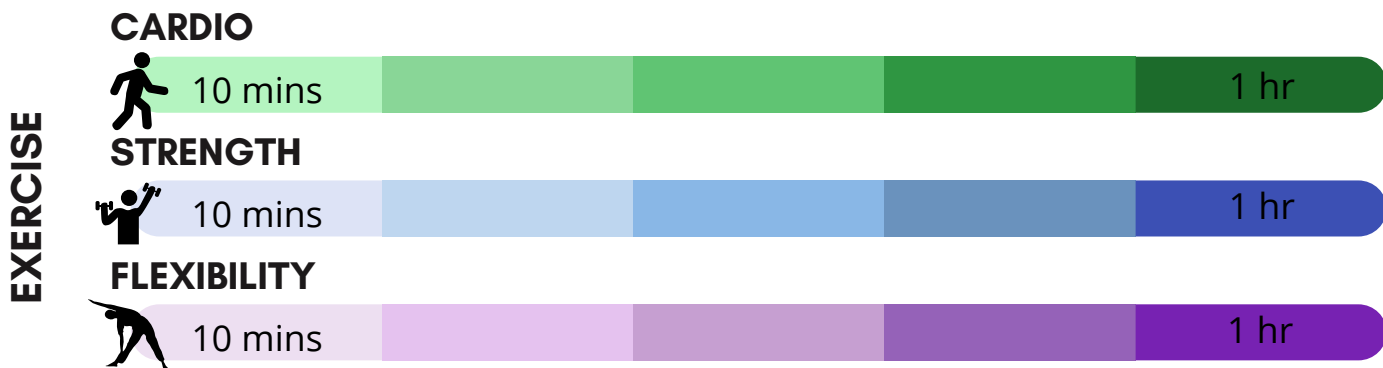
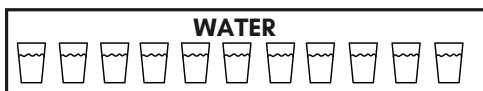


**OTHER SYMPTOMS**

- |                                   |                                     |                                       |                                      |
|-----------------------------------|-------------------------------------|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> Anger    | <input type="checkbox"/> Depression | <input type="checkbox"/> Fatigue      | <input type="checkbox"/> Lethargy    |
| <input type="checkbox"/> Anxiety  | <input type="checkbox"/> Diarrhea   | <input type="checkbox"/> Fever        | <input type="checkbox"/> Nausea      |
| <input type="checkbox"/> Bloating | <input type="checkbox"/> Congestion | <input type="checkbox"/> Irritability | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> Chills   | <input type="checkbox"/> Exhaustion | <input type="checkbox"/> Insomnia     | <input type="checkbox"/> Vomiting    |
| <input type="checkbox"/> _____    | <input type="checkbox"/> _____      | <input type="checkbox"/> _____        | <input type="checkbox"/> _____       |

**NOTES:**

	Breakfast Time :	Lunch	Dinner	Snacks
FOOD				



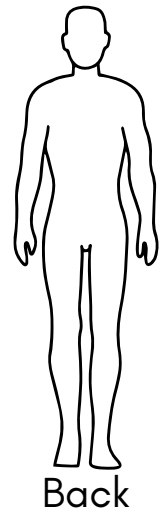
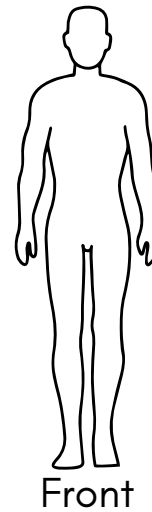
**OTHER**

Meditation    Journaling    Smoking: # \_\_\_\_    Alcohol: \_\_\_\_ oz.

Weight \_\_\_\_\_    Recreational Drugs    Pain Meds \_\_\_\_\_

Additional Medications used support	Time	Dose

Symptom Description	AM	PM

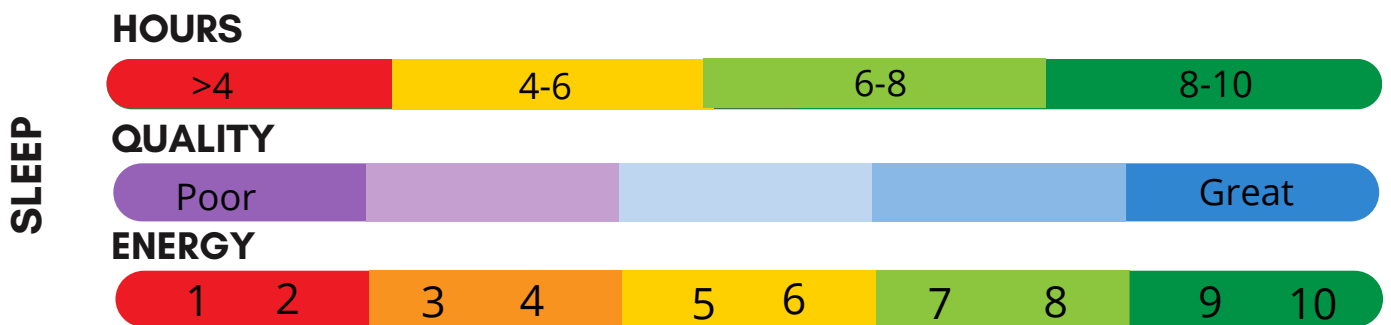
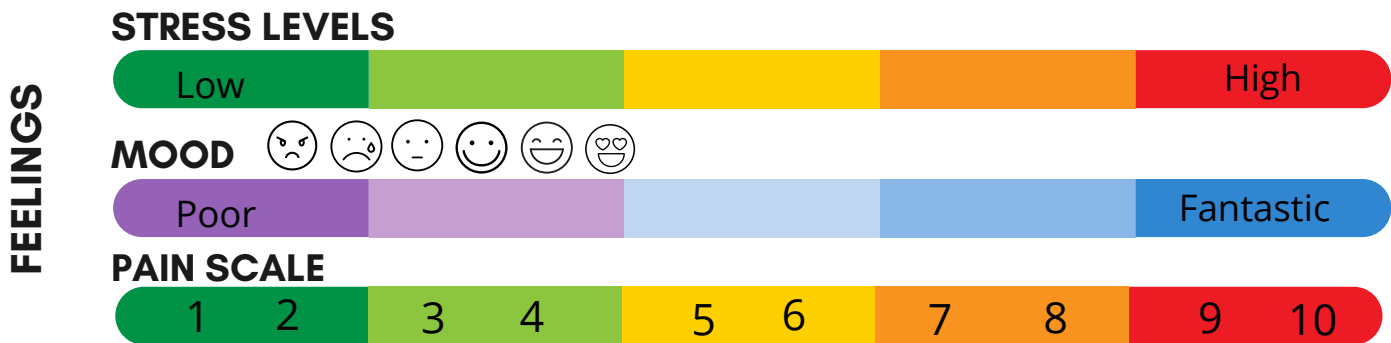
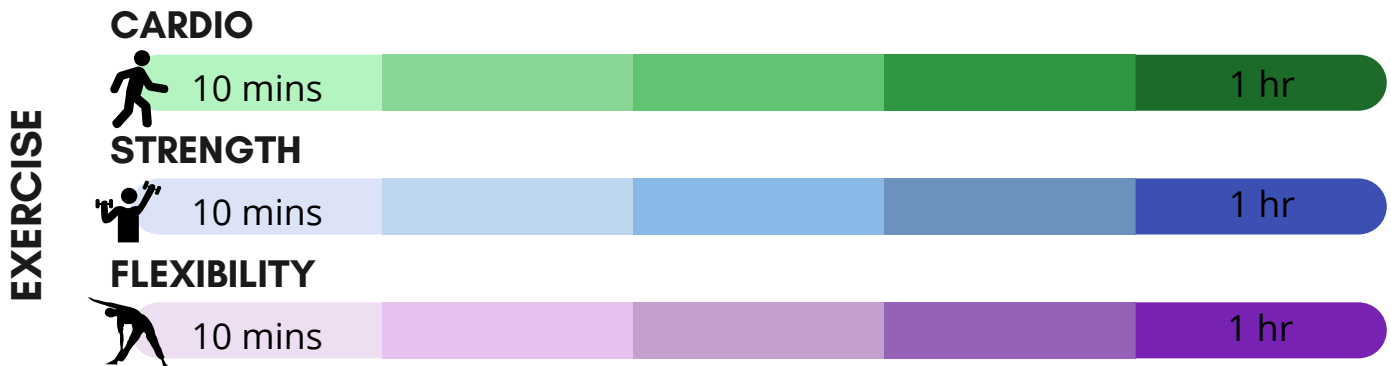
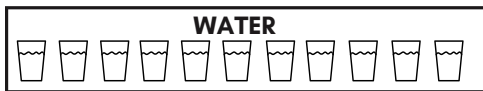


**OTHER SYMPTOMS**

- |                                   |                                     |                                       |                                      |
|-----------------------------------|-------------------------------------|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> Anger    | <input type="checkbox"/> Depression | <input type="checkbox"/> Fatigue      | <input type="checkbox"/> Lethargy    |
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| <input type="checkbox"/> _____    | <input type="checkbox"/> _____      | <input type="checkbox"/> _____        | <input type="checkbox"/> _____       |

**NOTES:**

	Breakfast Time :	Lunch	Dinner	Snacks
<b>FOOD</b>				



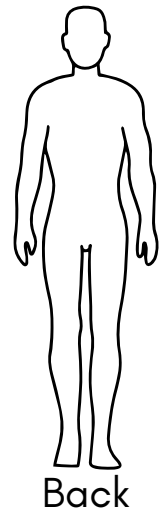
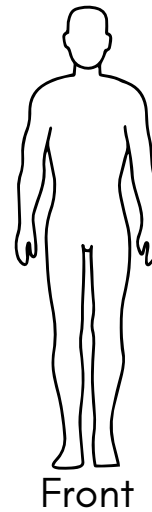
**OTHER**

Meditation    Journaling    Smoking: # \_\_\_\_    Alcohol: \_\_\_\_ oz.

Weight \_\_\_\_\_    Recreational Drugs    Pain Meds \_\_\_\_\_

Additional Medications used support	Time	Dose

Symptom Description	AM	PM

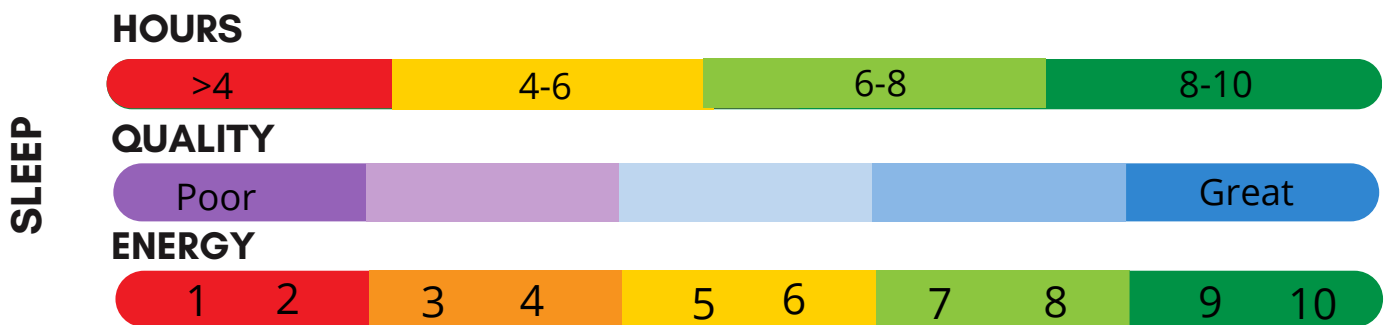
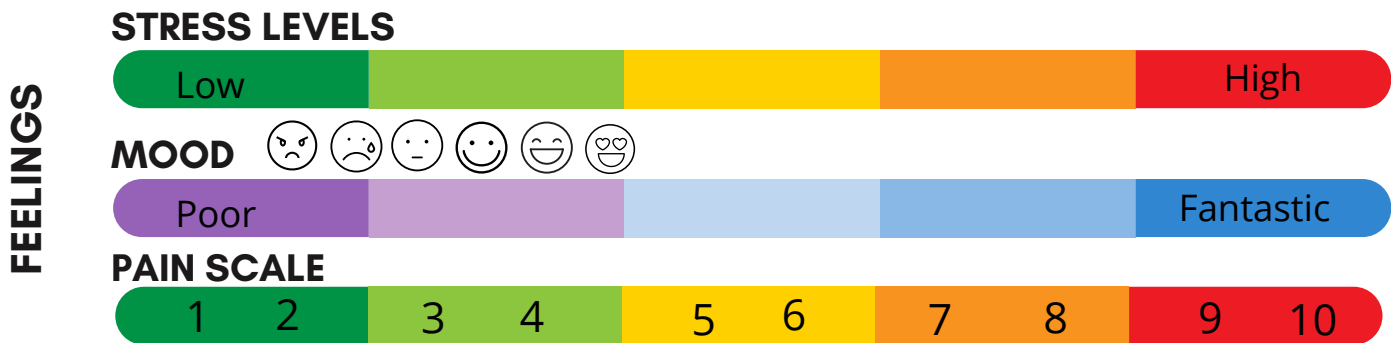
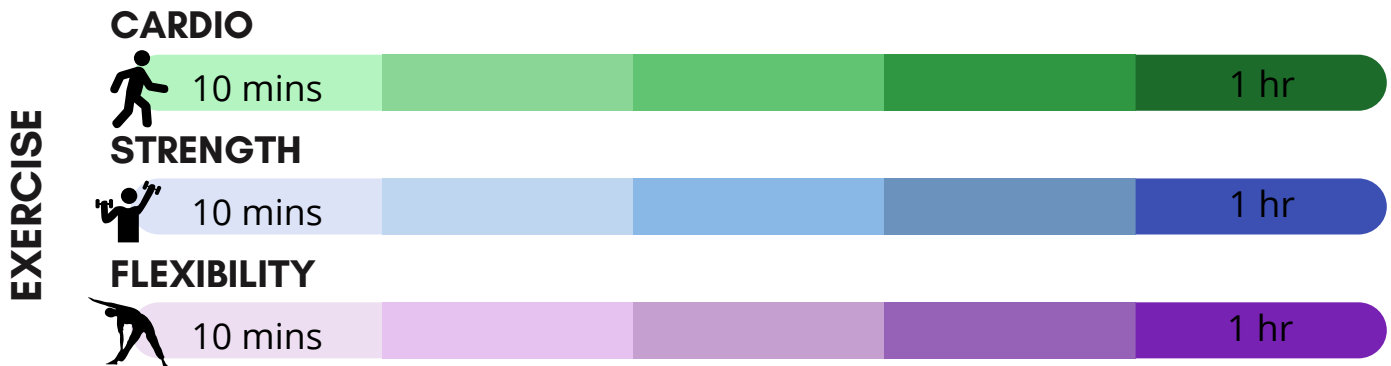


**OTHER SYMPTOMS**

- |                                   |                                     |                                       |                                      |
|-----------------------------------|-------------------------------------|---------------------------------------|--------------------------------------|
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| <input type="checkbox"/> Chills   | <input type="checkbox"/> Exhaustion | <input type="checkbox"/> Insomnia     | <input type="checkbox"/> Vomiting    |
| <input type="checkbox"/> _____    | <input type="checkbox"/> _____      | <input type="checkbox"/> _____        | <input type="checkbox"/> _____       |

**NOTES:**

	Breakfast Time :	Lunch	Dinner	Snacks
FOOD				



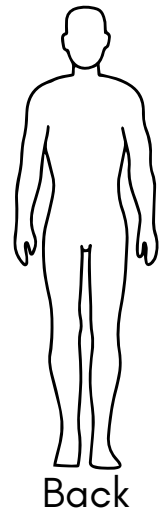
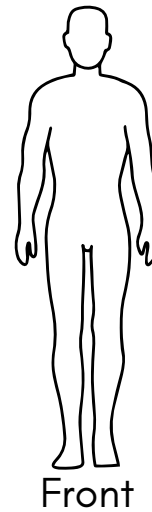
**OTHER**

Meditation    Journaling    Smoking: # \_\_\_\_    Alcohol: \_\_\_\_ oz.

Weight \_\_\_\_\_    Recreational Drugs    Pain Meds \_\_\_\_\_

Additional Medications used support	Time	Dose

Symptom Description	AM	PM



**OTHER SYMPTOMS**

- |                                   |                                     |                                       |                                      |
|-----------------------------------|-------------------------------------|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> Anger    | <input type="checkbox"/> Depression | <input type="checkbox"/> Fatigue      | <input type="checkbox"/> Lethargy    |
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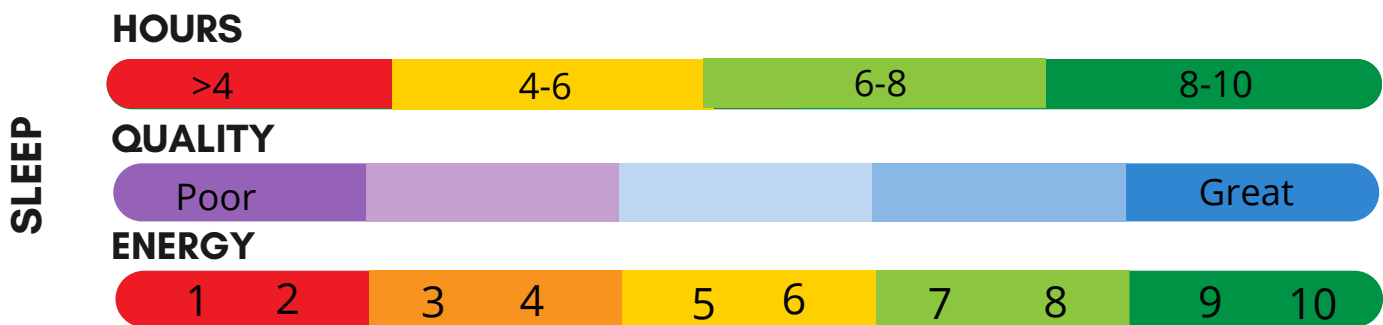
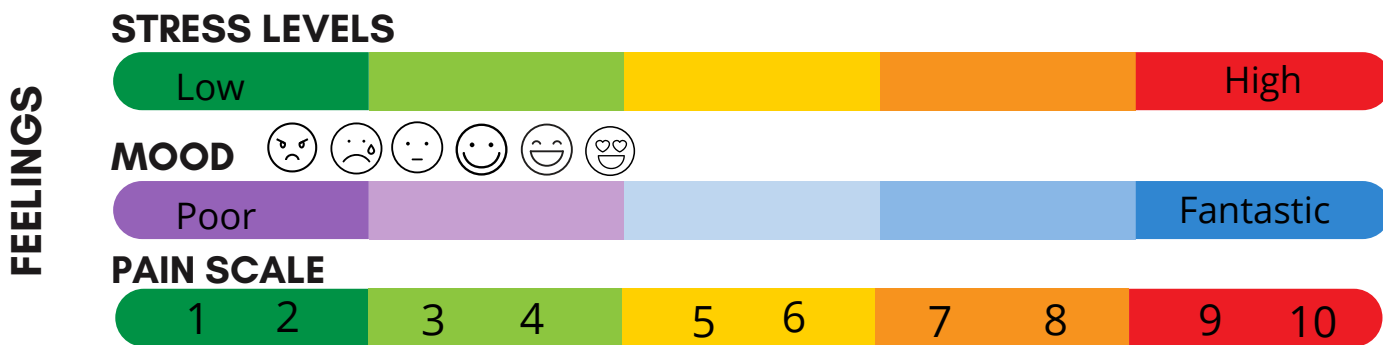
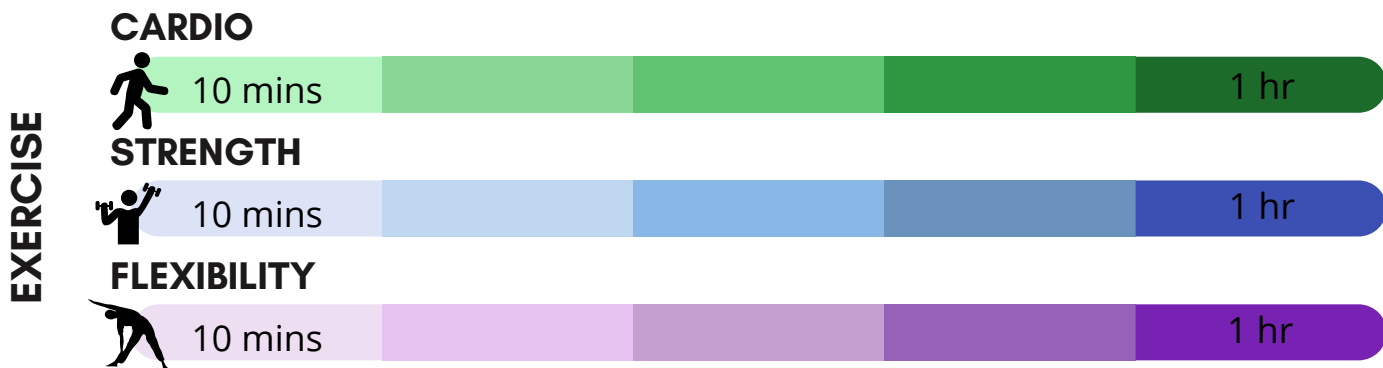
**NOTES:**



	Breakfast Time :	Lunch	Dinner	Snacks
FOOD				

**WATER**

**COFFEE/TEA**



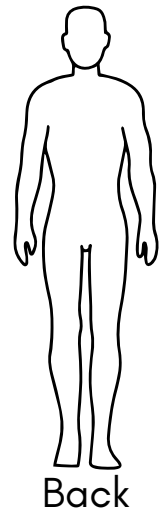
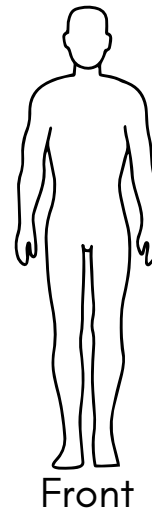
**OTHER**

Meditation    Journaling    Smoking: # \_\_\_\_    Alcohol: \_\_\_\_ oz.

Weight \_\_\_\_\_    Recreational Drugs    Pain Meds \_\_\_\_\_

Additional Medications used support	Time	Dose

Symptom Description	AM	PM

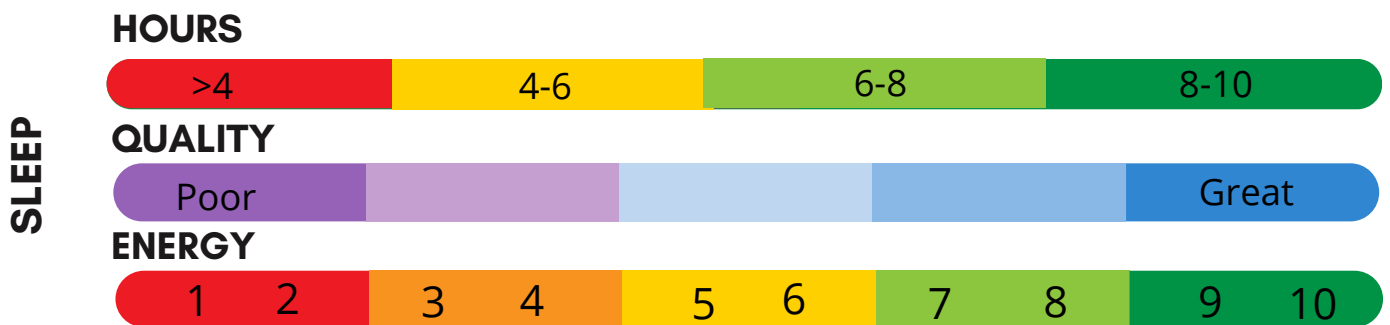
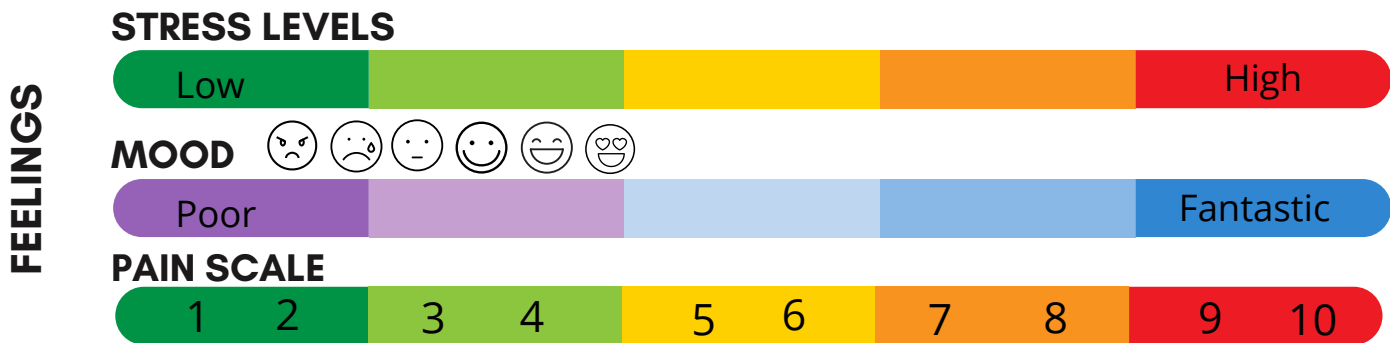
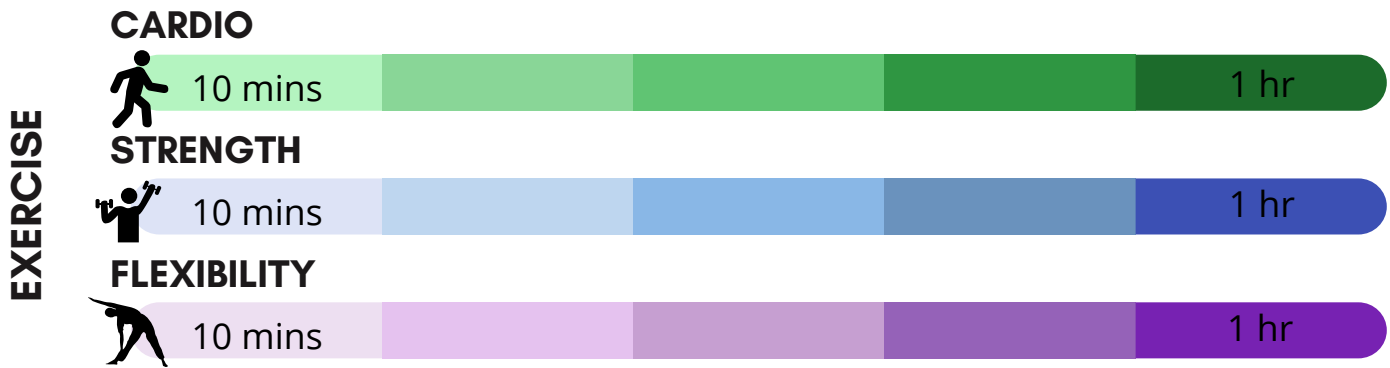


**OTHER SYMPTOMS**

- |                                   |                                     |                                       |                                      |
|-----------------------------------|-------------------------------------|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> Anger    | <input type="checkbox"/> Depression | <input type="checkbox"/> Fatigue      | <input type="checkbox"/> Lethargy    |
| <input type="checkbox"/> Anxiety  | <input type="checkbox"/> Diarrhea   | <input type="checkbox"/> Fever        | <input type="checkbox"/> Nausea      |
| <input type="checkbox"/> Bloating | <input type="checkbox"/> Congestion | <input type="checkbox"/> Irritability | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> Chills   | <input type="checkbox"/> Exhaustion | <input type="checkbox"/> Insomnia     | <input type="checkbox"/> Vomiting    |
| <input type="checkbox"/> _____    | <input type="checkbox"/> _____      | <input type="checkbox"/> _____        | <input type="checkbox"/> _____       |

**NOTES:**

	Breakfast Time :	Lunch	Dinner	Snacks
<b>FOOD</b>				



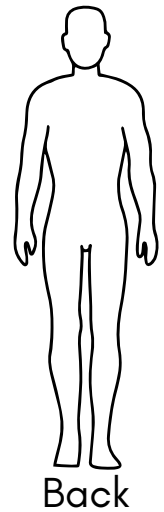
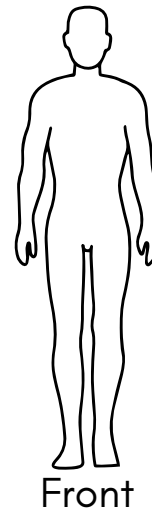
**OTHER**

Meditation    Journaling    Smoking: # \_\_\_\_    Alcohol: \_\_\_\_ oz.

Weight \_\_\_\_\_    Recreational Drugs    Pain Meds \_\_\_\_\_

Additional Medications used support	Time	Dose

Symptom Description	AM	PM



**OTHER SYMPTOMS**

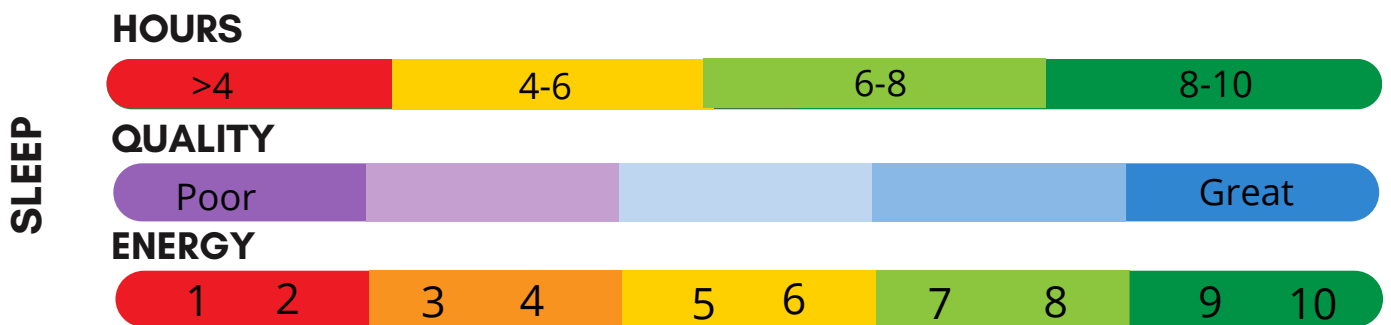
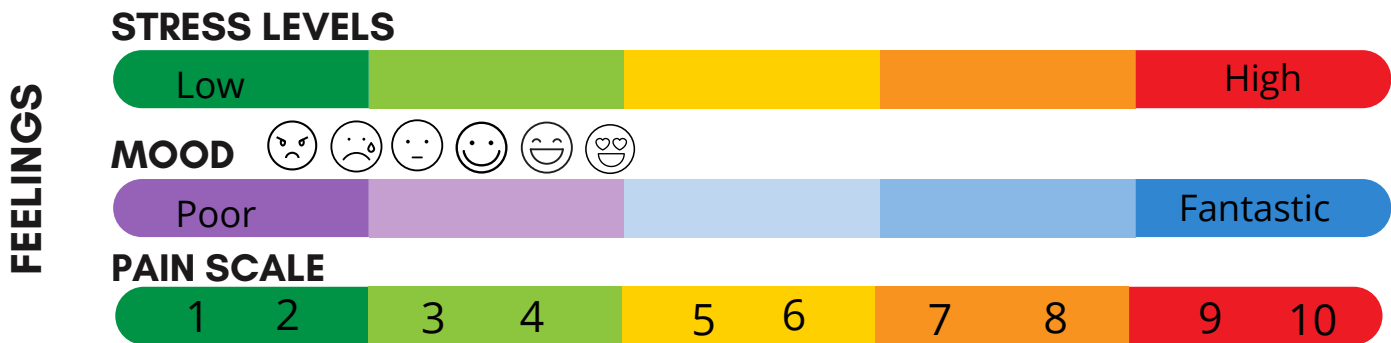
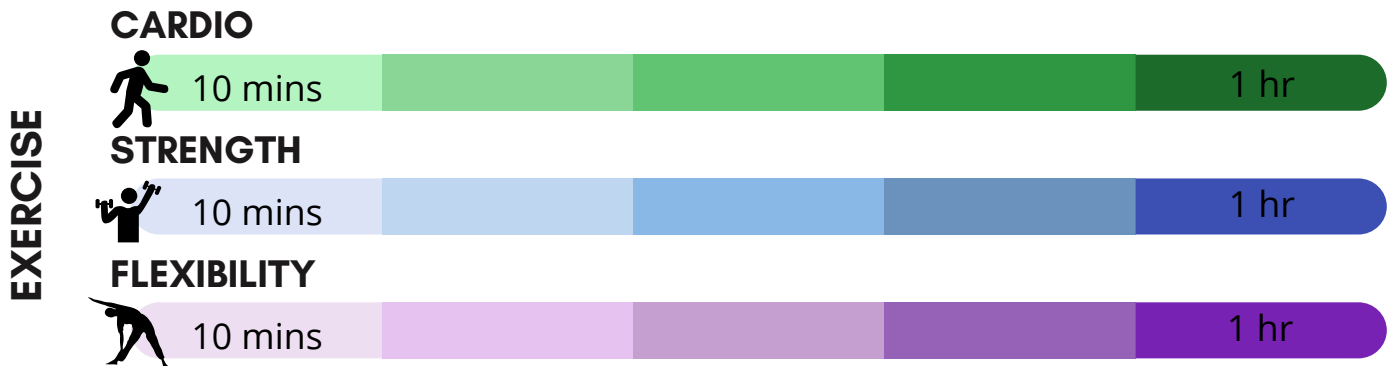
- |                                   |                                     |                                       |                                      |
|-----------------------------------|-------------------------------------|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> Anger    | <input type="checkbox"/> Depression | <input type="checkbox"/> Fatigue      | <input type="checkbox"/> Lethargy    |
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| <input type="checkbox"/> _____    | <input type="checkbox"/> _____      | <input type="checkbox"/> _____        | <input type="checkbox"/> _____       |

**NOTES:**

	Breakfast Time :	Lunch	Dinner	Snacks
FOOD				

**WATER**

**COFFEE/TEA**



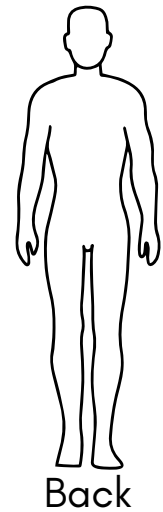
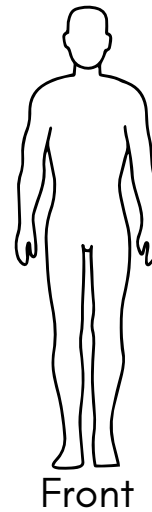
**OTHER**

Meditation    Journaling    Smoking: # \_\_\_\_    Alcohol: \_\_\_\_ oz.

Weight \_\_\_\_\_    Recreational Drugs    Pain Meds \_\_\_\_\_

Additional Medications used support	Time	Dose

Symptom Description	AM	PM



**OTHER SYMPTOMS**

- |                                   |                                     |                                       |                                      |
|-----------------------------------|-------------------------------------|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> Anger    | <input type="checkbox"/> Depression | <input type="checkbox"/> Fatigue      | <input type="checkbox"/> Lethargy    |
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| <input type="checkbox"/> _____    | <input type="checkbox"/> _____      | <input type="checkbox"/> _____        | <input type="checkbox"/> _____       |

**NOTES:**

	Breakfast Time :	Lunch	Dinner	Snacks
<b>FOOD</b>				

**WATER**

**COFFEE/TEA**

**EXERCISE**

**CARDIO**  
 10 mins 1 hr

**STRENGTH**  
 10 mins 1 hr

**FLEXIBILITY**  
 10 mins 1 hr

**FEELINGS**

**STRESS LEVELS**  
 Low High

**MOOD** 😡 😞 😐 😊 😄 😍  
 Poor Fantastic

**PAIN SCALE**  
 1 2 3 4 5 6 7 8 9 10

**SLEEP**

**HOURS**  
 >4 4-6 6-8 8-10

**QUALITY**  
 Poor Great

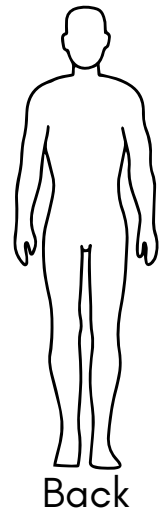
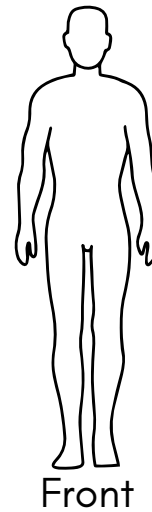
**ENERGY**  
 1 2 3 4 5 6 7 8 9 10

**OTHER**

Meditation  
  Journaling  
  Smoking: # \_\_\_\_  
  Alcohol: \_\_\_\_ oz.  
 Weight \_\_\_\_\_  
  Recreational Drugs  
  Pain Meds \_\_\_\_\_

Additional Medications used support	Time	Dose

Symptom Description	AM	PM



**OTHER SYMPTOMS**

- |                                   |                                     |                                       |                                      |
|-----------------------------------|-------------------------------------|---------------------------------------|--------------------------------------|
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| <input type="checkbox"/> _____    | <input type="checkbox"/> _____      | <input type="checkbox"/> _____        | <input type="checkbox"/> _____       |

**NOTES:**



	Breakfast Time :	Lunch	Dinner	Snacks
FOOD				

**WATER**

**COFFEE/TEA**

**EXERCISE**

**CARDIO** 10 mins 1 hr

**STRENGTH** 10 mins 1 hr

**FLEXIBILITY** 10 mins 1 hr

**FEELINGS**

**STRESS LEVELS** Low High

**MOOD** Poor Fantastic

**PAIN SCALE** 1 2 3 4 5 6 7 8 9 10

**SLEEP**

**HOURS** >4 4-6 6-8 8-10

**QUALITY** Poor Great

**ENERGY** 1 2 3 4 5 6 7 8 9 10

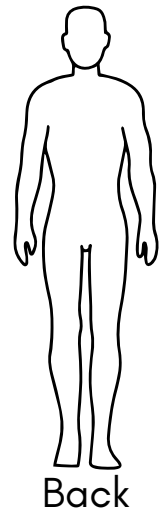
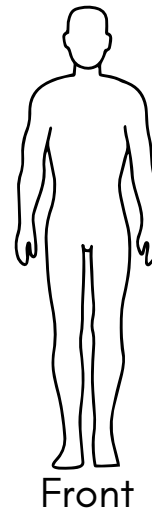
**OTHER**

Meditation    Journaling    Smoking: # \_\_\_\_    Alcohol: \_\_\_\_ oz.

Weight \_\_\_\_\_    Recreational Drugs    Pain Meds \_\_\_\_\_

Additional Medications used support	Time	Dose

Symptom Description	AM	PM

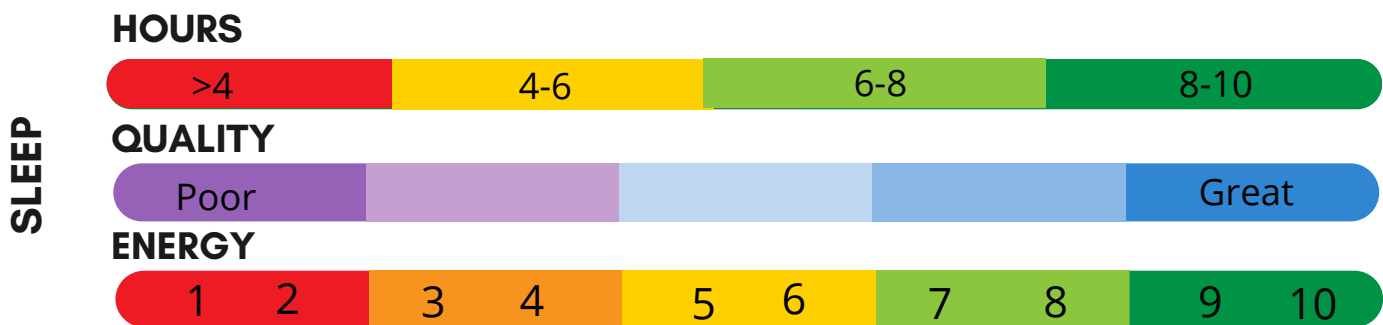
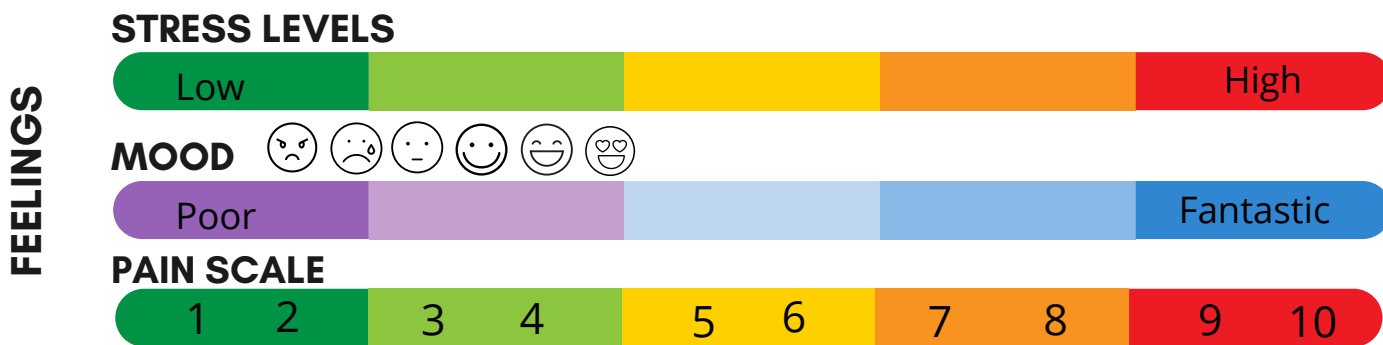
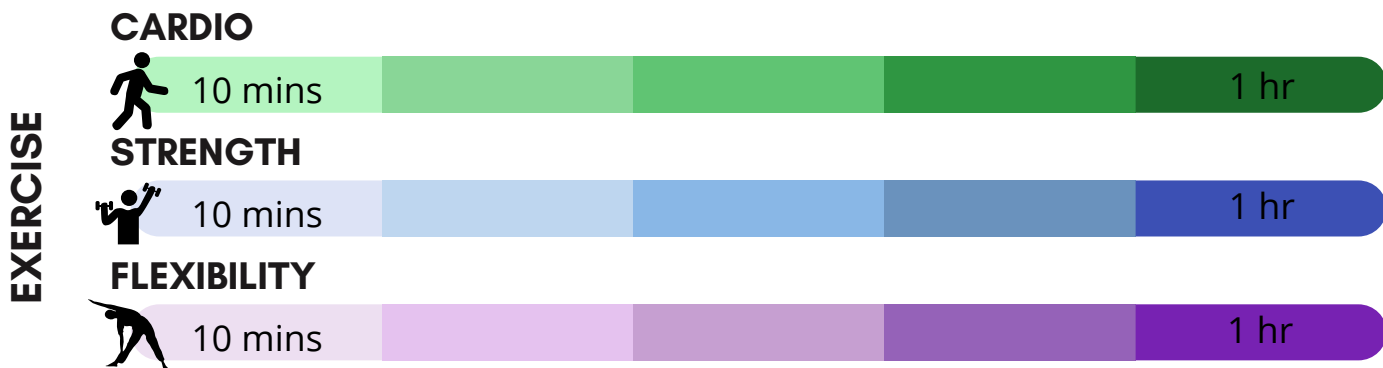
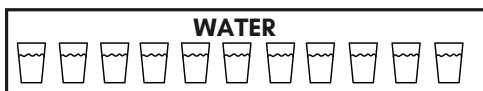


**OTHER SYMPTOMS**

- |                                   |                                     |                                       |                                      |
|-----------------------------------|-------------------------------------|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> Anger    | <input type="checkbox"/> Depression | <input type="checkbox"/> Fatigue      | <input type="checkbox"/> Lethargy    |
| <input type="checkbox"/> Anxiety  | <input type="checkbox"/> Diarrhea   | <input type="checkbox"/> Fever        | <input type="checkbox"/> Nausea      |
| <input type="checkbox"/> Bloating | <input type="checkbox"/> Congestion | <input type="checkbox"/> Irritability | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> Chills   | <input type="checkbox"/> Exhaustion | <input type="checkbox"/> Insomnia     | <input type="checkbox"/> Vomiting    |
| <input type="checkbox"/> _____    | <input type="checkbox"/> _____      | <input type="checkbox"/> _____        | <input type="checkbox"/> _____       |

**NOTES:**

	Breakfast Time :	Lunch	Dinner	Snacks
<b>FOOD</b>				



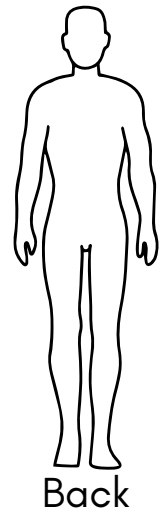
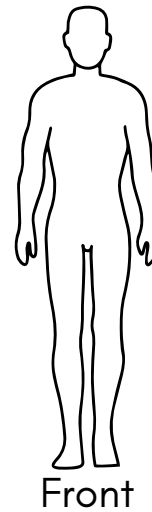
**OTHER**

Meditation    Journaling    Smoking: # \_\_\_\_    Alcohol: \_\_\_\_ oz.

Weight \_\_\_\_\_    Recreational Drugs    Pain Meds \_\_\_\_\_

Additional Medications used support	Time	Dose

Symptom Description	AM	PM

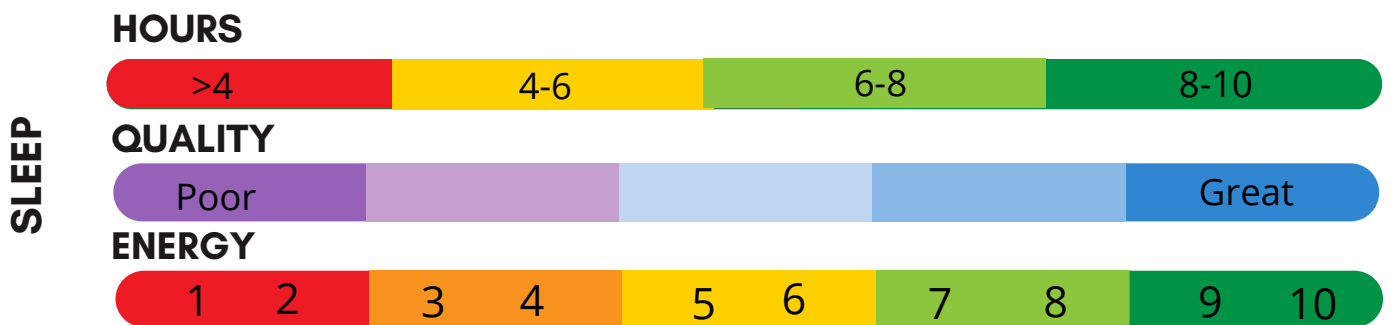
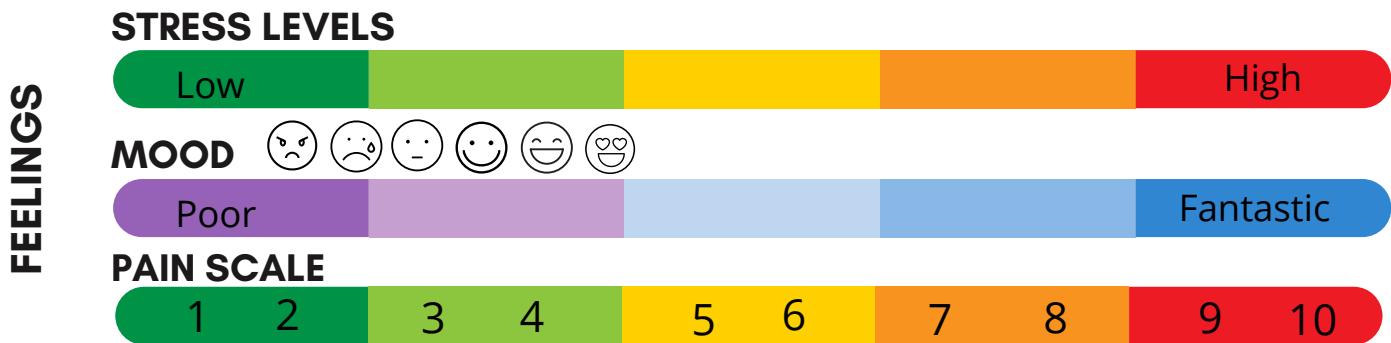
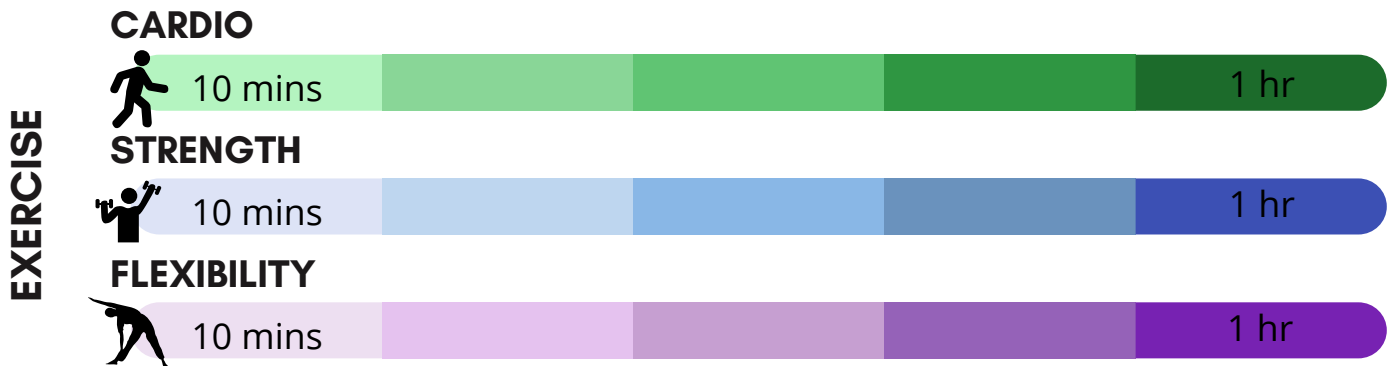
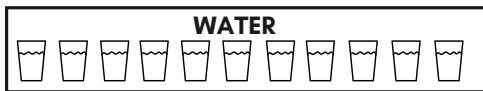


**OTHER SYMPTOMS**

- |                                   |                                     |                                       |                                      |
|-----------------------------------|-------------------------------------|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> Anger    | <input type="checkbox"/> Depression | <input type="checkbox"/> Fatigue      | <input type="checkbox"/> Lethargy    |
| <input type="checkbox"/> Anxiety  | <input type="checkbox"/> Diarrhea   | <input type="checkbox"/> Fever        | <input type="checkbox"/> Nausea      |
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| <input type="checkbox"/> Chills   | <input type="checkbox"/> Exhaustion | <input type="checkbox"/> Insomnia     | <input type="checkbox"/> Vomiting    |
| <input type="checkbox"/> _____    | <input type="checkbox"/> _____      | <input type="checkbox"/> _____        | <input type="checkbox"/> _____       |

**NOTES:**

	Breakfast Time :	Lunch	Dinner	Snacks
FOOD				



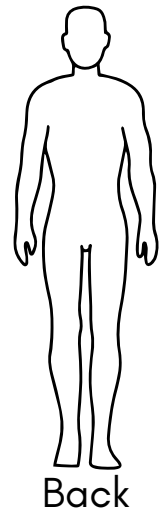
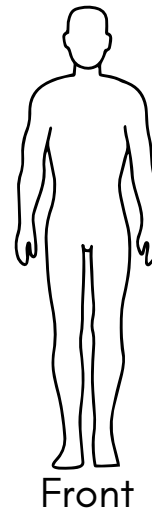
**OTHER**

Meditation    Journaling    Smoking: # \_\_\_\_    Alcohol: \_\_\_\_ oz.

Weight \_\_\_\_\_    Recreational Drugs    Pain Meds \_\_\_\_\_

Additional Medications used support	Time	Dose

Symptom Description	AM	PM



**OTHER SYMPTOMS**

- |                                   |                                     |                                       |                                      |
|-----------------------------------|-------------------------------------|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> Anger    | <input type="checkbox"/> Depression | <input type="checkbox"/> Fatigue      | <input type="checkbox"/> Lethargy    |
| <input type="checkbox"/> Anxiety  | <input type="checkbox"/> Diarrhea   | <input type="checkbox"/> Fever        | <input type="checkbox"/> Nausea      |
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| <input type="checkbox"/> _____    | <input type="checkbox"/> _____      | <input type="checkbox"/> _____        | <input type="checkbox"/> _____       |

**NOTES:**

	Breakfast Time :	Lunch	Dinner	Snacks
FOOD				

**WATER**

**COFFEE/TEA**

**EXERCISE**

**CARDIO** 10 mins 1 hr

**STRENGTH** 10 mins 1 hr

**FLEXIBILITY** 10 mins 1 hr

**FEELINGS**

**STRESS LEVELS** Low High

**MOOD** Poor Fantastic

**PAIN SCALE** 1 2 3 4 5 6 7 8 9 10

**SLEEP**

**HOURS** >4 4-6 6-8 8-10

**QUALITY** Poor Great

**ENERGY** 1 2 3 4 5 6 7 8 9 10

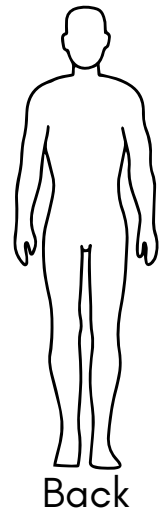
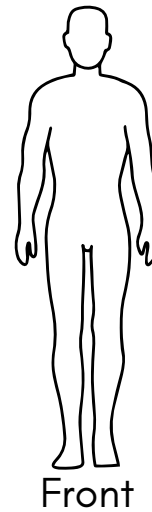
**OTHER**

Meditation    Journaling    Smoking: # \_\_\_\_    Alcohol: \_\_\_\_ oz.

Weight \_\_\_\_\_    Recreational Drugs    Pain Meds \_\_\_\_\_

Additional Medications used support	Time	Dose

Symptom Description	AM	PM



**OTHER SYMPTOMS**

- |                                   |                                     |                                       |                                      |
|-----------------------------------|-------------------------------------|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> Anger    | <input type="checkbox"/> Depression | <input type="checkbox"/> Fatigue      | <input type="checkbox"/> Lethargy    |
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| <input type="checkbox"/> _____    | <input type="checkbox"/> _____      | <input type="checkbox"/> _____        | <input type="checkbox"/> _____       |

**NOTES:**



	Breakfast Time :	Lunch	Dinner	Snacks
<b>FOOD</b>				

**WATER**

**COFFEE/TEA**

**EXERCISE**

**CARDIO**  
 10 mins 1 hr

**STRENGTH**  
 10 mins 1 hr

**FLEXIBILITY**  
 10 mins 1 hr

**FEELINGS**

**STRESS LEVELS**  
 Low High

**MOOD** 😡 😞 😐 😊 😄 😍  
 Poor Fantastic

**PAIN SCALE**  
 1 2 3 4 5 6 7 8 9 10

**SLEEP**

**HOURS**  
 >4 4-6 6-8 8-10

**QUALITY**  
 Poor Great

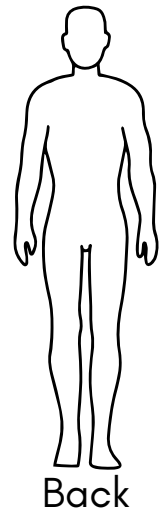
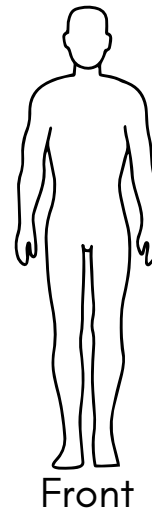
**ENERGY**  
 1 2 3 4 5 6 7 8 9 10

**OTHER**

Meditation  
  Journaling  
  Smoking: # \_\_\_\_  
  Alcohol: \_\_\_\_ oz.  
 Weight \_\_\_\_\_  
  Recreational Drugs  
  Pain Meds \_\_\_\_\_

Additional Medications used support	Time	Dose

Symptom Description	AM	PM

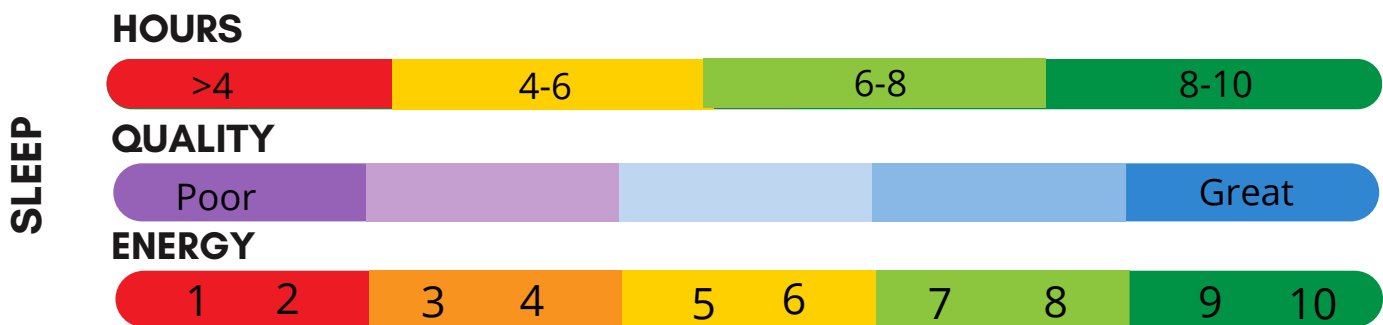
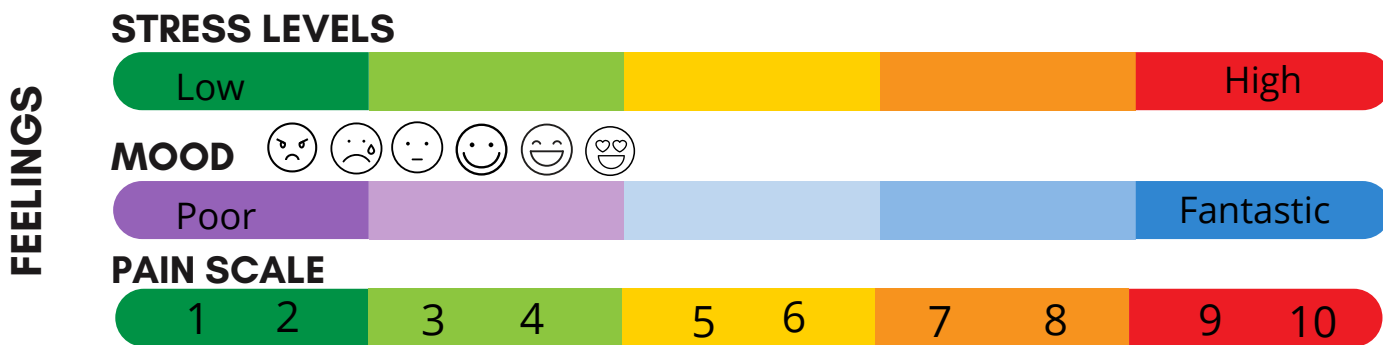
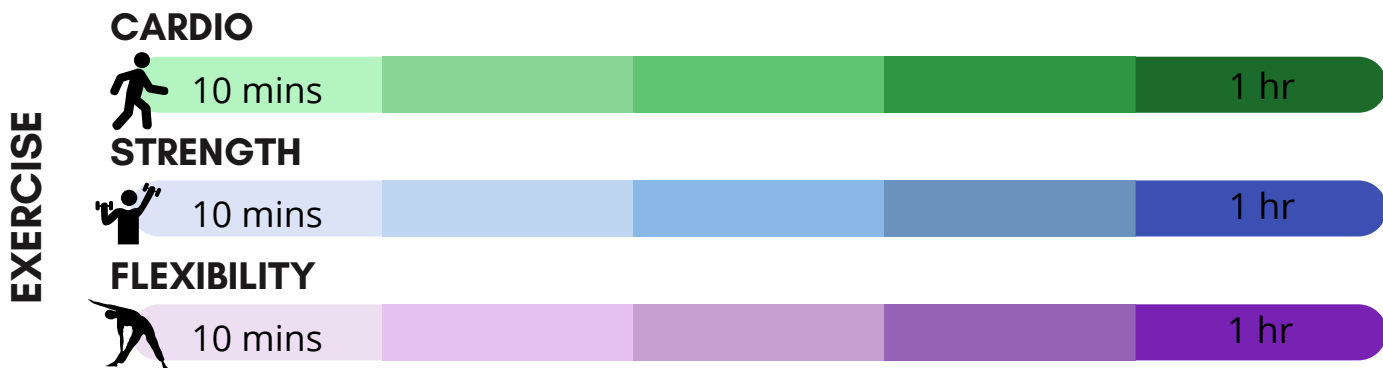
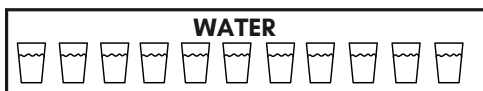


**OTHER SYMPTOMS**

- |                                   |                                     |                                       |                                      |
|-----------------------------------|-------------------------------------|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> Anger    | <input type="checkbox"/> Depression | <input type="checkbox"/> Fatigue      | <input type="checkbox"/> Lethargy    |
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| <input type="checkbox"/> Bloating | <input type="checkbox"/> Congestion | <input type="checkbox"/> Irritability | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> Chills   | <input type="checkbox"/> Exhaustion | <input type="checkbox"/> Insomnia     | <input type="checkbox"/> Vomiting    |
| <input type="checkbox"/> _____    | <input type="checkbox"/> _____      | <input type="checkbox"/> _____        | <input type="checkbox"/> _____       |

**NOTES:**

	Breakfast Time :	Lunch	Dinner	Snacks
FOOD				



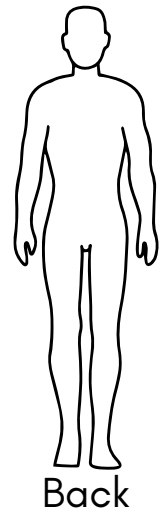
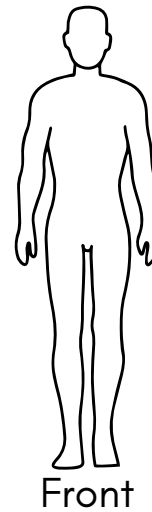
**OTHER**

Meditation    Journaling    Smoking: # \_\_\_\_    Alcohol: \_\_\_\_ oz.

Weight \_\_\_\_\_    Recreational Drugs    Pain Meds \_\_\_\_\_

Additional Medications used support	Time	Dose

Symptom Description	AM	PM

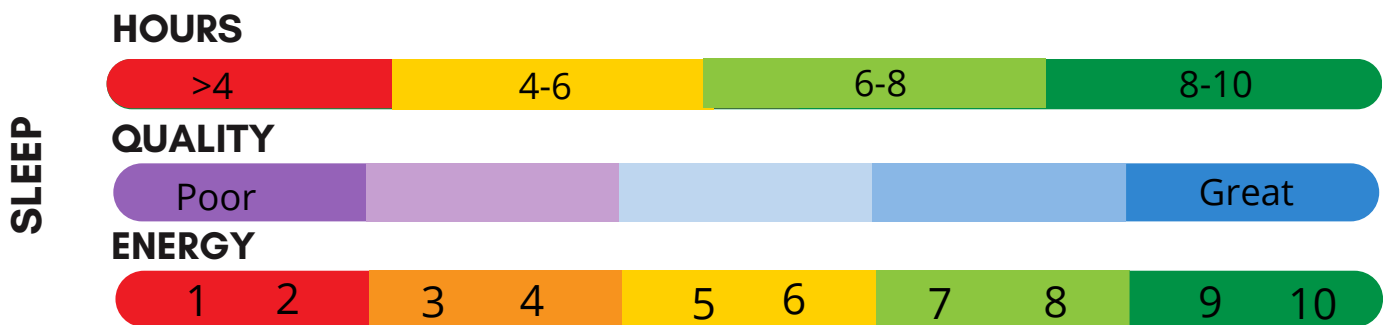
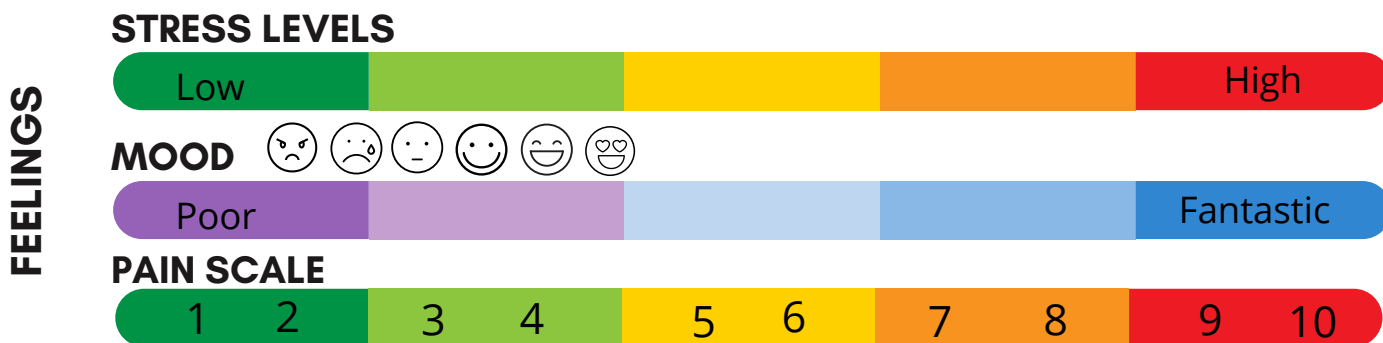
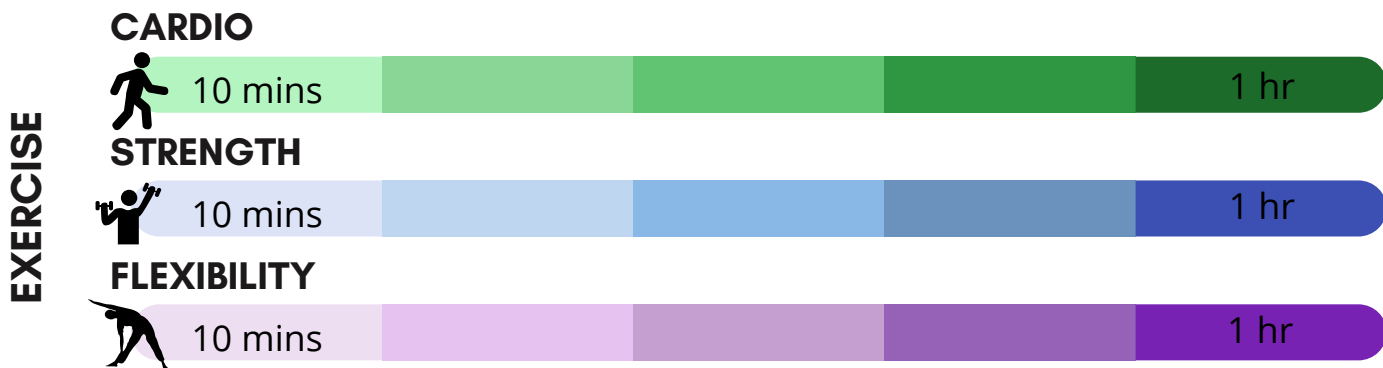
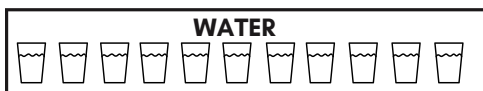


**OTHER SYMPTOMS**

- |                                   |                                     |                                       |                                      |
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**NOTES:**

	Breakfast Time :	Lunch	Dinner	Snacks
FOOD				



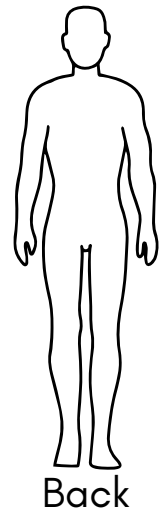
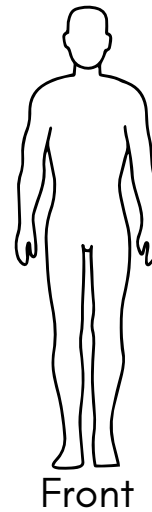
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Meditation    Journaling    Smoking: # \_\_\_\_    Alcohol: \_\_\_\_ oz.

Weight \_\_\_\_\_    Recreational Drugs    Pain Meds \_\_\_\_\_

Additional Medications used support	Time	Dose

Symptom Description	AM	PM

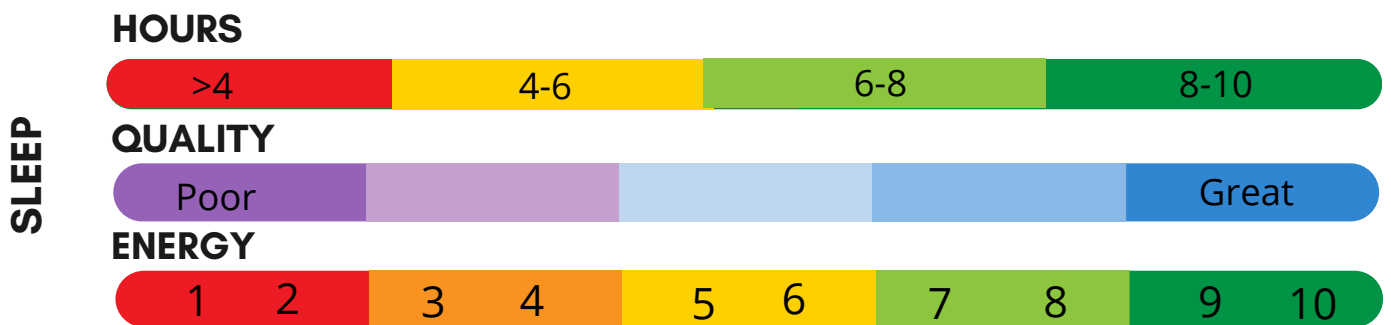
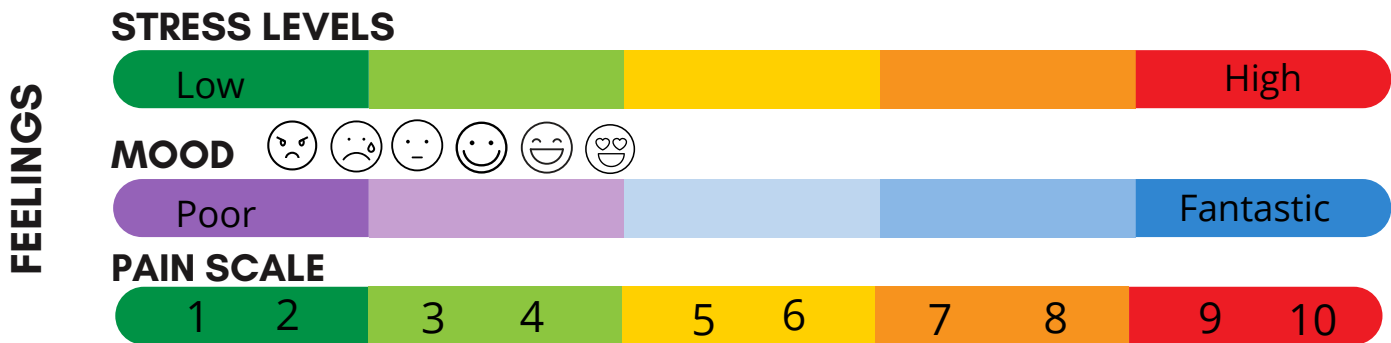
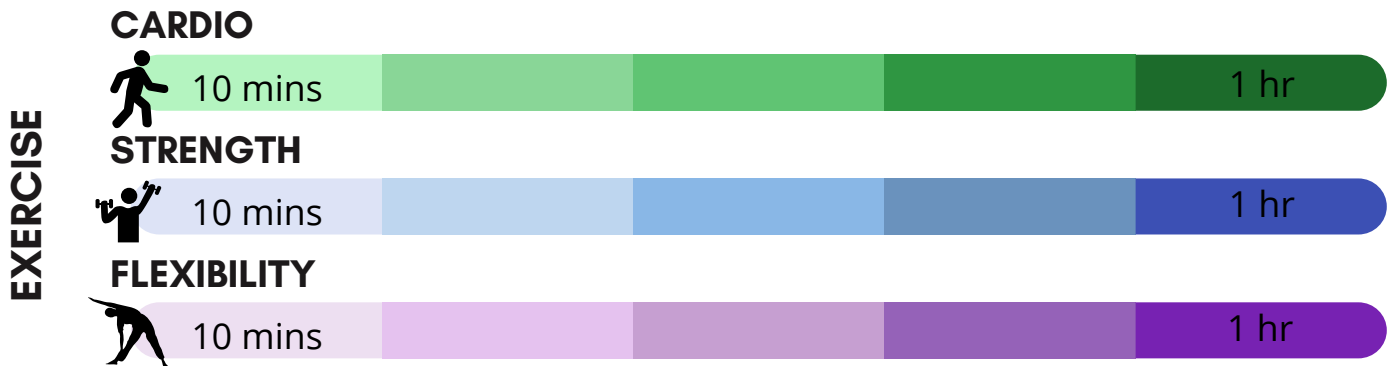


**OTHER SYMPTOMS**

- |                                   |                                     |                                       |                                      |
|-----------------------------------|-------------------------------------|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> Anger    | <input type="checkbox"/> Depression | <input type="checkbox"/> Fatigue      | <input type="checkbox"/> Lethargy    |
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| <input type="checkbox"/> _____    | <input type="checkbox"/> _____      | <input type="checkbox"/> _____        | <input type="checkbox"/> _____       |

**NOTES:**

	Breakfast Time :	Lunch	Dinner	Snacks
<b>FOOD</b>				



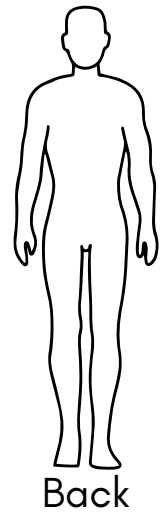
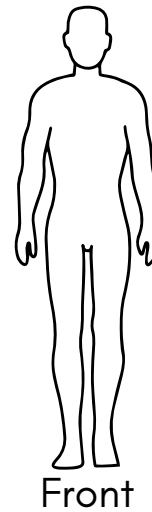
**OTHER**

Meditation    Journaling    Smoking: # \_\_\_\_    Alcohol: \_\_\_\_ oz.

Weight \_\_\_\_\_    Recreational Drugs    Pain Meds \_\_\_\_\_

Additional Medications used support	Time	Dose

Symptom Description	AM	PM



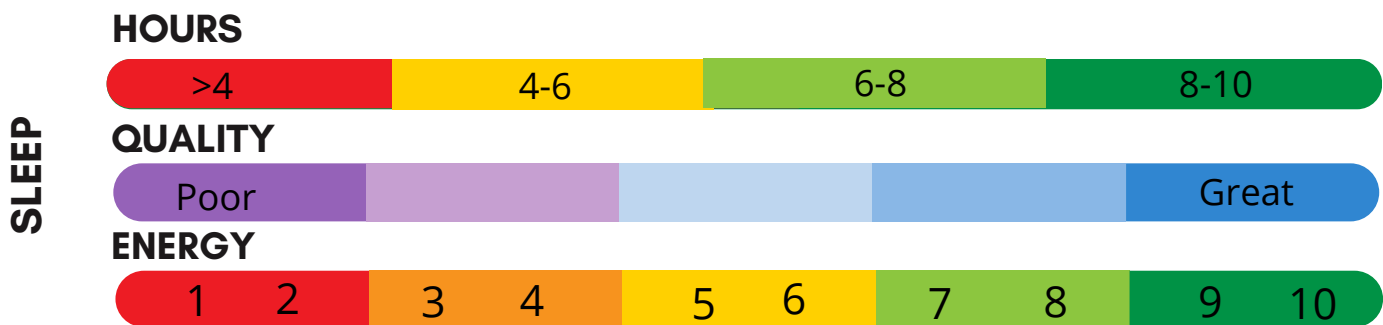
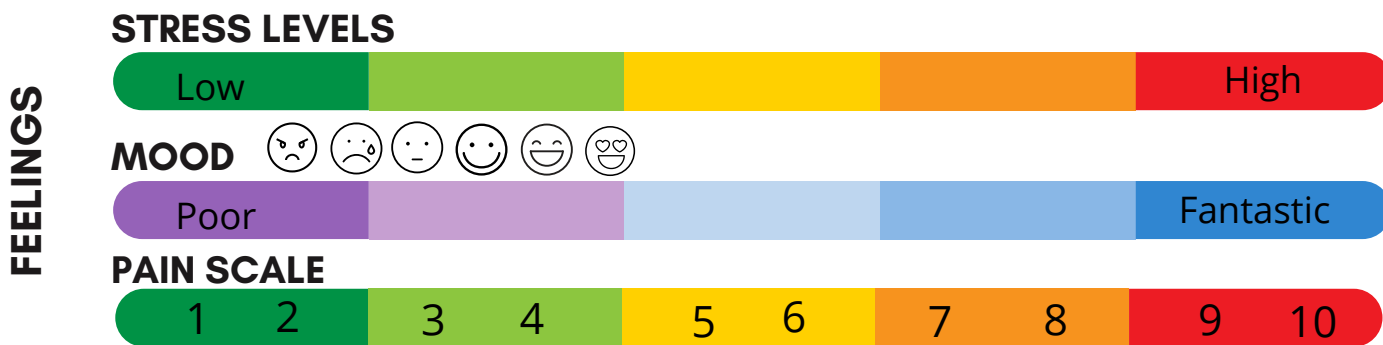
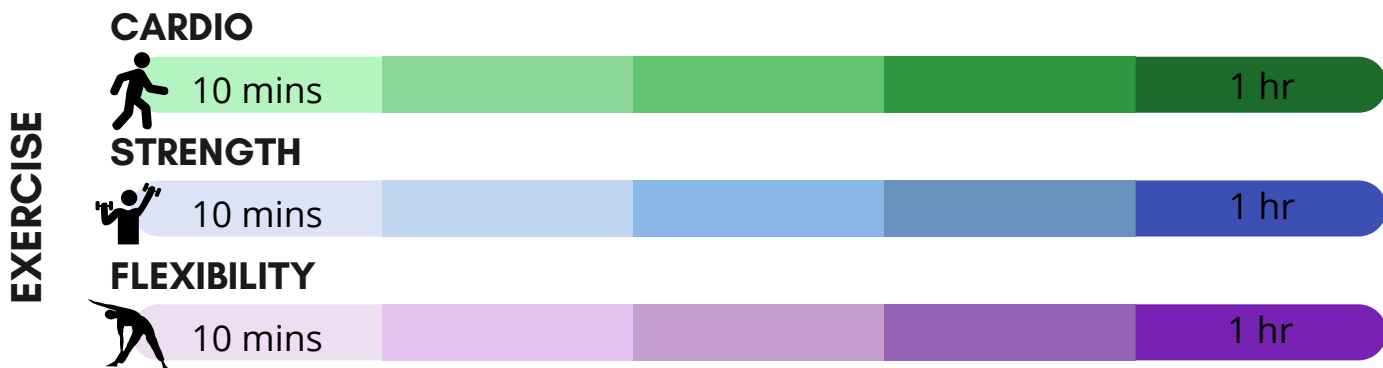
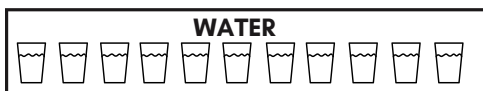
**OTHER SYMPTOMS**

- |                                   |                                     |                                       |                                      |
|-----------------------------------|-------------------------------------|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> Anger    | <input type="checkbox"/> Depression | <input type="checkbox"/> Fatigue      | <input type="checkbox"/> Lethargy    |
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**NOTES:**



	Breakfast Time :	Lunch	Dinner	Snacks
<b>FOOD</b>				



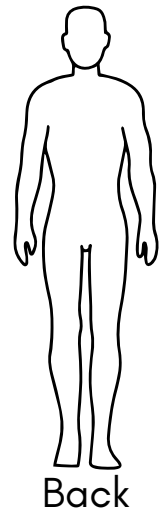
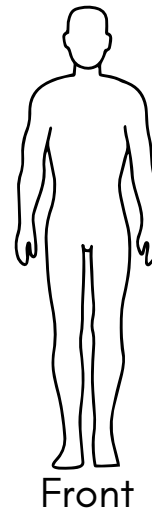
**OTHER**

Meditation    Journaling    Smoking: # \_\_\_\_    Alcohol: \_\_\_\_ oz.

Weight \_\_\_\_\_    Recreational Drugs    Pain Meds \_\_\_\_\_

Additional Medications used support	Time	Dose

Symptom Description	AM	PM



**OTHER SYMPTOMS**

- |                                   |                                     |                                       |                                      |
|-----------------------------------|-------------------------------------|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> Anger    | <input type="checkbox"/> Depression | <input type="checkbox"/> Fatigue      | <input type="checkbox"/> Lethargy    |
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| <input type="checkbox"/> _____    | <input type="checkbox"/> _____      | <input type="checkbox"/> _____        | <input type="checkbox"/> _____       |

**NOTES:**

	Breakfast Time :	Lunch	Dinner	Snacks
<b>FOOD</b>				

**WATER**

**COFFEE/TEA**

**EXERCISE**

**CARDIO** 10 mins

**STRENGTH** 10 mins

**FLEXIBILITY** 10 mins

**FEELINGS**

**STRESS LEVELS**

**MOOD**

**PAIN SCALE**

**SLEEP**

**HOURS**

**QUALITY**

**ENERGY**

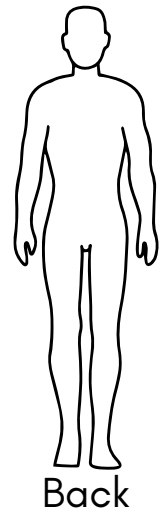
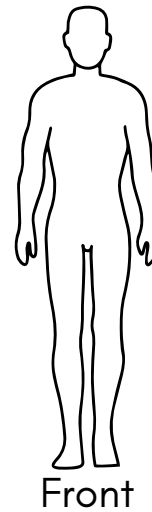
**OTHER**

Meditation    Journaling    Smoking: # \_\_\_\_    Alcohol: \_\_\_\_ oz.

Weight \_\_\_\_\_    Recreational Drugs    Pain Meds \_\_\_\_\_

Additional Medications used support	Time	Dose

Symptom Description	AM	PM



**OTHER SYMPTOMS**

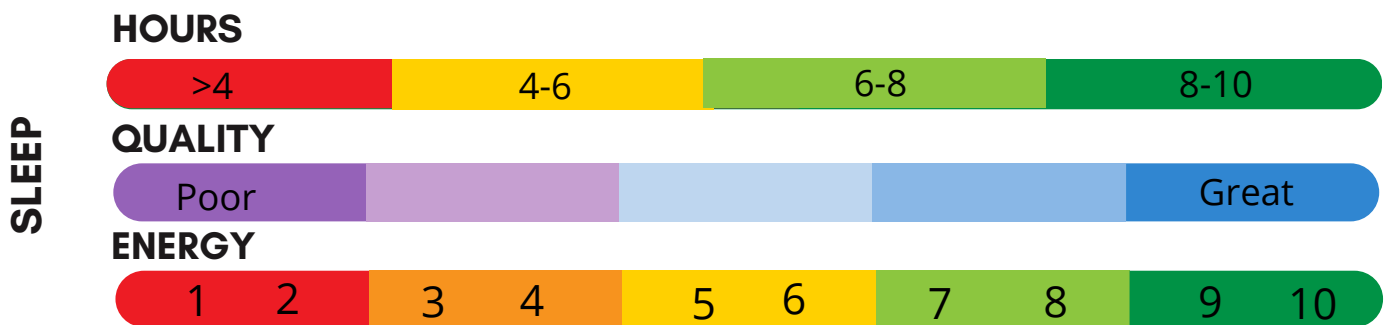
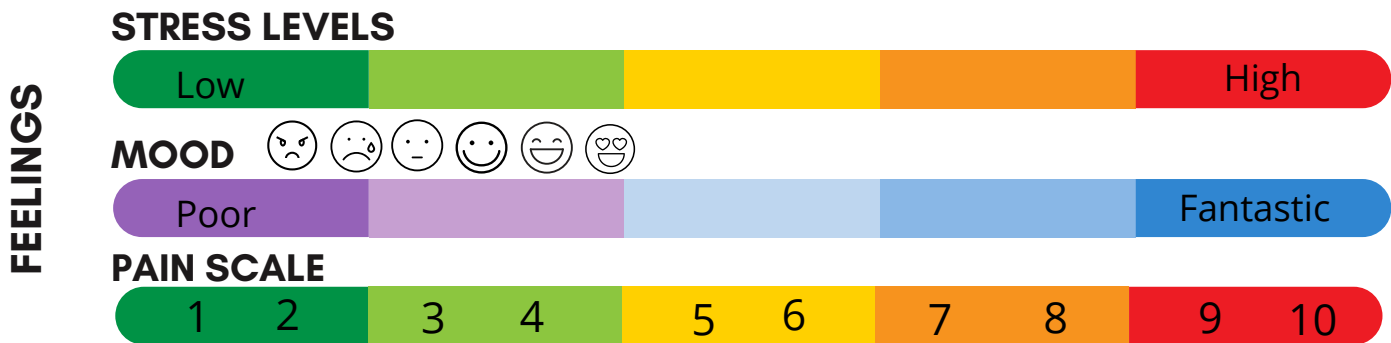
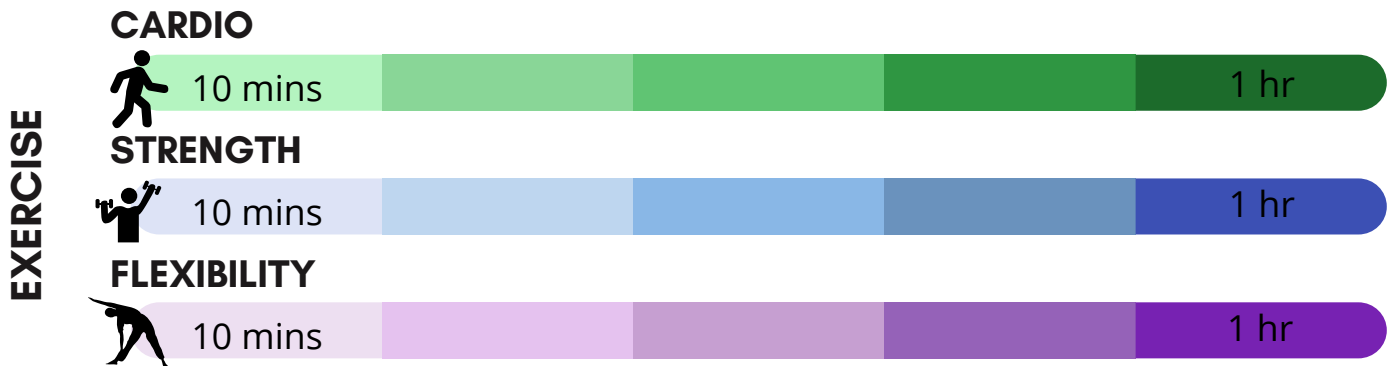
- |                                   |                                     |                                       |                                      |
|-----------------------------------|-------------------------------------|---------------------------------------|--------------------------------------|
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| <input type="checkbox"/> _____    | <input type="checkbox"/> _____      | <input type="checkbox"/> _____        | <input type="checkbox"/> _____       |

**NOTES:**

	Breakfast Time :	Lunch	Dinner	Snacks
<b>FOOD</b>				

**WATER**

**COFFEE/TEA**

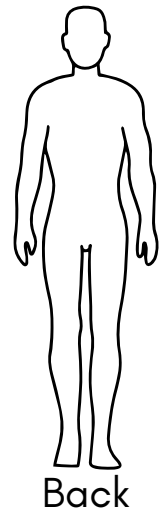
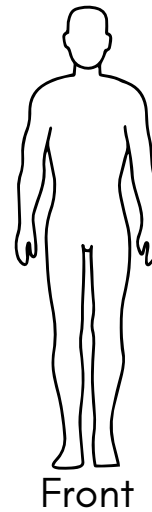


**OTHER**

Meditation  
  Journaling  
  Smoking: # \_\_\_\_  
  Alcohol: \_\_\_\_ oz.  
 Weight \_\_\_\_\_  
  Recreational Drugs  
  Pain Meds \_\_\_\_\_

Additional Medications used support	Time	Dose

Symptom Description	AM	PM



**OTHER SYMPTOMS**

- |                                   |                                     |                                       |                                      |
|-----------------------------------|-------------------------------------|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> Anger    | <input type="checkbox"/> Depression | <input type="checkbox"/> Fatigue      | <input type="checkbox"/> Lethargy    |
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| <input type="checkbox"/> _____    | <input type="checkbox"/> _____      | <input type="checkbox"/> _____        | <input type="checkbox"/> _____       |

**NOTES:**

HABITS

Healthy Eating Rating (1-10): \_\_\_\_\_ Total days of Meditation: \_\_\_\_\_  
 Total Days you Drank all your Water: \_\_\_\_\_ Total days of Journalling: \_\_\_\_\_  
 Total Days you Exercised: \_\_\_\_\_ Total cigarettes smoked: \_\_\_\_\_  
 Total Days Stress was High: \_\_\_\_\_ Total oz. of Alcohol: \_\_\_\_\_  
 Total Days Pain was 4 or above: \_\_\_\_\_ Recreational Drug Use: \_\_\_\_\_  
 Average Energy Level: \_\_\_\_\_

SYMPTOMS PROGRESSION

SEVERITY SCALE



Symptoms	Date/ Pain #	Date/ Pain #	Date/ Pain #	Date/ Pain #	Date/ Pain #	Date/ Pain #

OTHER IMPORTANT NOTES

Blank area for notes.

# MONTHLY CALENDAR



MON	TUE	WED	THU	FRI	SAT	SUN

## NOTES
