MONTHLY SUMMARY

This summary will help you visualize how your symptoms are trending daily.

Month & Year:		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Overall: Notice the Trend of How you Feel Overall Overtime and How You Feel Better or Worse As Factors Below Change. Color the icon to show how you feel.																																
How Do I Feel Overall?	Really Good																															
	Good																															
	OK																															
	Bad																															
	Really Bad																															
Influencing Factors: Track These Influencing Factors And Notice Improvements In Symptoms With Consistency. Add 1 for Yes, 0 for No.																																
Did I Sleep Well?																																
Did I Eat Healthy Balanced Meals?																																
Was I Active For At Least 30 Mins?																																
Did I Drink Enough Water?																																
Sum of the Scores Above for Each Day: Add the 1's and circle the number below. Join The Dots																																
4: Great Keep It Up																																
3: Almost There																																
2: You Can Do It																																
1: Let's Try Again Tomorrow																																
0: Evaluate What's Stopping You																																
Symptoms Tracker: Notice How Your Symptoms Change Over Time And How They Co-Relate With The Factors Above And How You Feel Overall. Join the Dots																																
Overall Daily Fatigue Levels	Severe																															
	Moderate																															
	Mild																															
	None																															
Overall Daily Pain Levels (Joint Pain, Stiffness, Muscle Pain, Cramps, Other Aches & Pains)	Severe																															
	Moderate																															
	Mild																															
	None																															

This is not a diagnostics or a medical survey. Please consult with your medical provider for any questions or concerns. We assume no liability

OTHER SYMPTOMS

Add other symptoms or markers you would like to track. Enter the Name of Each One Below.

Month & Year:	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
Symptoms/Marker Name:																															
Severe																															
Moderate																															
Mild																															
None																															
Symptoms/Marker Name:																															
Severe																															
Moderate																															
Mild																															
None																															
Symptoms/Marker Name:																															
Severe																															
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Mild																															
None																															
Symptoms/Marker Name:																															
Severe																															
Moderate																															
Mild																															
None																															

DAILY SYMPTOM TRACKER

DATE: _____

M T W T F S S

Time	Symptoms & How am I Feeling?	What Did I Eat or Not Eat?	What did I do or Not do?	Other Potential Triggers (Sleep, Stress etc)	Severity Scale *1: Mild | 2: Mod | 3: Severe*	What Am I going to Do About It?
					1 2 3	
					1 2 3	
					1 2 3	
					1 2 3	

Medication/Supplements	**Weather & Activity**	**Sleep Duration (hours)**	**Food & Drink**	**Water Intake**	**Stress/ Mood**
Took Regulars Meds/Supplements: ☐		4 5 6 7 8 9 10	Balance Meals: ☐		
Notes:	Notes:	Notes:	Notes:	Notes:	Notes:

BOWEL MOVEMENTS					**Time:**
					
1 No Bowel or Severe Constipation	2 Mild Constipation	3 Normal	4 Lacking Fibre	5 Mild Diarrhoea	6 Severe Diarrhoea