



# WELLNESS LOG

KEEP PERSONAL TRACK OF YOUR DAY-TO-DAY WELLNESS TO HELP NOTE PATTERNS IN IMPROVEMENT OR DECLINE. REVIEW THESE CHANGES WITH YOUR PHYSICIAN ON YOUR NEXT VISIT.

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Notes:

Pain Scale (1 no pain, 10 extreme pain):

1     2     3     4     5     6     7     8     9     10

Energy Scale (1 low energy, 10 high energy):

1     2     3     4     5     6     7     8     9     10

Sleep Scale (1 poor sleep, 10 good sleep):

1     2     3     4     5     6     7     8     9     10

Other Symptom Scale (1 lowest, 10 highest):

Symptom: \_\_\_\_\_

1     2     3     4     5     6     7     8     9     10

Worst Symptoms:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Improved Symptoms:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Additional Concerns:



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Date: \_\_\_\_\_

Name: \_\_\_\_\_

Notes:

Pain Scale (1 no pain, 10 extreme pain):

<input type="checkbox"/>									
1	2	3	4	5	6	7	8	9	10

Energy Scale (1 low energy, 10 high energy):

<input type="checkbox"/>									
1	2	3	4	5	6	7	8	9	10

Sleep Scale (1 poor sleep, 10 good sleep):

<input type="checkbox"/>									
1	2	3	4	5	6	7	8	9	10

Other Symptom Scale (1 lowest, 10 highest):

Symptom: \_\_\_\_\_

<input type="checkbox"/>									
1	2	3	4	5	6	7	8	9	10

Worst Symptoms:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Improved Symptoms:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Additional Concerns: