your treatment journal

Print your journal entries for a binder or save them to your computer for future reference.

Date: _____ Time: _____

Symptoms

What symptoms are you experiencing today before starting treatment?

PAIN: (1) (2) (3) (4) (5)
mild *severe*
Type: _____

HEADACHE: (1) (2) (3) (4) (5)
mild *severe*
Type: _____

MUSCLE SPASM: (1) (2) (3) (4) (5)
mild *severe*
Type: _____

CRAMPING: (1) (2) (3) (4) (5)
mild *severe*
Type: _____

INSOMNIA: (1) (2) (3) (4) (5)
mild *severe*
Type: _____

NAUSEA: (1) (2) (3) (4) (5)
mild *severe*
Type: _____

APPETITE LOSS: (1) (2) (3) (4) (5)
mild *severe*
Type: _____

ANXIETY: (1) (2) (3) (4) (5)
mild *severe*
Type: _____

DEPRESSION: (1) (2) (3) (4) (5)
mild *severe*
Type: _____

DIZZINESS: (1) (2) (3) (4) (5)
mild *severe*
Type: _____

SEIZURES: (1) (2) (3) (4) (5)
mild *severe*
Type: _____

OTHER: (1) (2) (3) (4) (5)
mild *severe*
Type: _____

Dosage

STRAIN: _____ APPROXIMATE AMOUNT CONSUMED: _____

THC: _____ CBD: _____ ☐ VAPOURIZED ☐ INGESTED ☐ TOPICAL ☐ SMOKED

Effects

POSITIVE:

- ☐ *Anti-Depressant*
- ☐ *Anti-Inflammatory*
- ☐ *Appetite Stimulator*
- ☐ *Creative*
- ☐ *Energetic*
- ☐ *Focused*
- ☐ *Intestinal Ease*
- ☐ *Muscle Relaxation*
- ☐ *Pain Relief*
- ☐ *Sedative*
- ☐ *Seizure Reduction*
- ☐ *Other:* _____

NEGATIVE:

- ☐ *Anxiety*
- ☐ *Couch Lock*
- ☐ *Dizziness*
- ☐ *Drowsy*
- ☐ *Dry Eyes*
- ☐ *Dry Mouth*
- ☐ *Headache*
- ☐ *Nausea*
- ☐ *Paranoia*
- ☐ *Other:* _____

Experience Summary

Track your progress over time to understand how different strains, methods of consumption, and time of day affect your experience.

_____

_____

_____

_____

_____

_____

Overall Outcome

Place a check mark on the scale below to indicate your overall feeling of wellness after taking your treatment.

-5 -4 -3 -2 -1 0 1 2 3 4 5

worse *no change* *better*