My Symptom Management Journal

Date: Time: AM/PM

Symptom:

Duration: When did the symptom(s) begin? How long did it last?

Intensity: On a scale of 0-10 (10 being the worst you have experienced), how would you describe your symptom(s)?

Location: Where are you experiencing the symptom(s)? Be specific.

Possible Triggers: What makes it worse?

Possible Relief/Treatment: What provides relief?

Because of this symptom, I have been unable to engage in the following activities:

Questions or instructions from my health care team:

Spoke to: Time: AM/PM

Suggested strategies for symptom management:

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