How did you feel today?

Date: ______________
(MM/DD/YY)

For each feeling, circle a number between 1 and 5 to describe how strongly you felt that feeling today (1=very little, 2=a little, 3=medium, 4=strong; 5=very strong). You may include comments that explain how you felt. If you did not have any of the feelings listed here, do not circle a number. You may also write in a feeling (bottom row) that was not already included in this list and rate it from 1 to 5.

Restless 1 2 3 4 5	**Angry/Irritated** 1 2 3 4 5	**Anxious** 1 2 3 4 5
Comment	*Comment*	*Comment*
Fuzzy Head 1 2 3 4 5	**Memory Problems** 1 2 3 4 5	**Concentration Problems** 1 2 3 4 5
Comment	*Comment*	*Comment*
Jittery/Nervous 1 2 3 4 5	**Drowsy** 1 2 3 4 5	**Difficulty Sleeping** 1 2 3 4 5
Comment	*Comment*	*Comment*
Change in Appetite 1 2 3 4 5	**Dry Mouth** 1 2 3 4 5	**Upset Stomach** 1 2 3 4 5
Comment	*Comment*	*Comment*
Constipated 1 2 3 4 5	**Reduced Sex Drive** 1 2 3 4 5	**Lightheaded** 1 2 3 4 5
Comment	*Comment*	*Comment*
1 2 3 4 5	1 2 3 4 5	
Comment	*Comment*	

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How did you feel this week?

Week of: ____________________
(MM/DD/YY)

For each feeling, write in a number between 1 and 10 to describe how strongly you felt it each day, with 1 being very little and 10 being very strong. If you did not have one of the feelings listed here in a given day, write 0 for that day. You may also write in a feeling that was not already included in this list and rate it from 1 to 10.

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7
Day of the Week							
Restless							
Angry/Irritated							
Anxious							
Fuzzy Head							
Memory Problems							
Concentration Problems							
Jittery/Nervous							
Drowsy							
Difficulty Sleeping							
Change in Appetite							
Dry Mouth							
Upset Stomach							
Constipated							
Reduced Sex Drive							
Lightheaded							

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