Name _____Month/Year _____Medication:_____capsule(s) _____ time(s) a day _____mg of _____

Medication #2 :_____capsule(s) _____ time(s) a day _____mg of _____

Medication #3:_____capsule(s) _____ time(s) a day _____mg of _____

Medication #4:_____capsule(s) _____ time(s) a day _____mg of _____

Circle the date when you entered information on THAT day (you can enter information for any previous day based on memory

	Symptom	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
a	**tick bite**																															
b	**rash**																															
c	**skin sensitivity**																															
d																																
e	**muscle pain/cramps**																															
f	**muscle twitching**																															
g	**paralysis or tremor**																															
h	**tingling, numbness**																															
i	**burning, stabbing pain**																															
j	**joint pain, swelling**																															
k	**stiffness**																															
l																																
m	**sexual dysfunction**																															
n	**irregular menstrual**																															
o	**testical/pelvic pain**																															
p	**stomach dysfunction**																															
q	**bladder dysfunction**																															
r	**bowel dysfunction**																															
s	**heart dysfunction**																															
t																																
u	**eye dysfunction**																															
v	**ear dysfunction**																															
w	**speech dysfunction**																															
x	**sleep dysfunction**																															
y																																
z	**headache**																															
aa	**dizziness, balance**																															
bb	**motion sickness**																															
cc	**concentration**																															
dd	**short term memory loss**																															
ee	**confusion**																															
ff	**moody/depression**																															
gg																																
hh	**alcoholic reaction**																															
ii	**chest pain**																															
jj	**breath shortness**																															
kk	**fever/chills**																															
ll	**fatigue**																															
mm	**swollen glands**																															
nn	**sore throat/coughing**																															
oo	**hair loss/weight change**																															

No Symptom - leave blank Mild symptom - put a dash (**-**) Bothersome symptom - put a slash (/) Restricts Normal Activities - put an **X** SEVERE symptom - fill in box completely