

Daily Journal

Recovery Check List

Daily Chart

Feeling Great
Feeling O.K.
Tired
Exhausted
Pain Level - (Scale: 1 2 3 4)

AM

NOON

PM

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

REMEMBER

Add To Meals:

Glasses of Water

1 2 3 4
5 6 7 8

Fruit 1 2 3 4

Vegetables

1 2 3 4

Supplements

1 2 3

Mouth Care: _____

Hours of Sleep: _____

Quality of Sleep: _____

Food Diary

AM (Breakfast) _____

AM (Snack) _____

NOON (Lunch) _____

PM (Snack) _____

PM (Dinner) _____

PM (Snack) _____

MEDICATIONS

Name

Times

Given

Dosage

_____	_____	_____
_____	_____	_____
_____	_____	_____