KILL PARKINSON

From Diagnosis to Daily Life — **Practical Tools That Make a Difference.**

Your Life. Your Voice. Your Fight.

The Essential Parkinson's Guide Printable Tools

English Edition

Author: Alexandra Robuste

Welcome to Your Essential PD Toolkit

Living with Parkinson's means keeping track of a lot — symptoms, medications, appointments, sleep, mood, energy, food. It's a lot to hold in your head. This toolkit is here to help.

These pages are yours. Print them, fill them in digitally, use one tracker or all of them — however they fit into your life. There is no right or wrong way. The goal is simply to make your days a little clearer, your appointments a little more productive, and your patterns a little easier to see.

Every tool in this kit was designed with real daily life in mind — not clinical perfection, but the kind of honest, practical tracking that actually helps you and your care team understand what's going on.

Use them today. Use them next month. Come back whenever you need a fresh page. You are not managing this alone. We are behind you — every step of the way.

Imprint

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⚠ *Medical Disclaimer — Please Read Before You Begin*

This guide/ trackers do not provide medical advice.
The information contained in this publication is intended for general informational and educational purposes only. It is not a substitute for professional medical advice, diagnosis, or treatment of any kind.

Never disregard professional medical advice or delay seeking it because of something you have read in this guide. Always consult your neurologist, physician, or a qualified healthcare provider before making any changes to your medication, therapy, diet, exercise routine, or any other aspect of your health management.

Parkinson's disease is a complex, individual condition. What works for one person may not work for another — and may even be harmful.

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Liability
Kill Parkinson gemeinnützige UG publishes this guide as part of its non-profit awareness mission. The purpose of this publication is to raise awareness about Parkinson's disease and make information more accessible to patients, caregivers, families, and the wider community. By making this information publicly available, we aim to support informed discussions with qualified healthcare professionals and promote greater understanding of the condition. This publication is intended solely for informational purposes and should not be interpreted as medical advice.

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Author
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Scientific Review
Melinda Barkhuizen, PhD

PERSONAL INFORMATION

For Medical & Emergency Use

PERSONAL DETAILS

Full Name: _____

Date of Birth: _____

Address: _____

_____

_____

Phone: _____

Email: _____

Preferred Language: _____

MEDICAL ALERT

Diagnosis: _____

Year Diagnosed: _____

Medication timing is:

☐ Flexible ☐ **CRITICAL — must be on time**

Allergies: _____

Medications: _____

_____

Other (food, etc.): _____

_____

EMERGENCY CONTACTS

Primary Contact

Name: _____

Relationship: _____

Phone: _____

Secondary Contact

Name: _____

Relationship: _____

Phone: _____

Additional Contact (optional)

Name: _____

Relationship: _____

Phone: _____

MEDICATION SUMMARY

MEDICATION	DOSE	TIME(S) TAKEN

IMPORTANT NOTE

Do not delay or skip Parkinson's medication.
Even short delays can cause serious complications.

PHARMACY

Pharmacy Name: _____

Phone: _____

Address: _____

_____

_____

DOCTORS & CARE TEAM

Neurologist / Movement Disorder Specialist

Name: _____

Clinic / Hospital: _____

Phone: _____

Email (optional): _____

Primary Care Physician

Name: _____

Phone: _____

Clinic: _____

Other Specialists (if any)

Specialist: _____ Phone: _____

Specialist: _____ Phone: _____

Specialist: _____ Phone: _____

PARKINSON'S OVERVIEW

Typical OFF Symptoms:

_____

_____

_____

Known Triggers (if any):

_____

_____

_____

Symptoms / Issues (check all that apply):

☐ Dyskinesia ☐ Freezing ☐ Tremor

☐ Rigidity ☐ Balance Issues ☐ Fall Risk

☐ Swallowing Issues ☐ Orthostatic Hypotension

Other Notes:

_____

_____

_____

MEDICAL DEVICES

☐ Deep Brain Stimulator (DBS)
Device Card Location: _____

☐ Other Device: _____

Notes: _____

_____

_____

INSURANCE INFORMATION

Insurance Provider: _____

Policy Number: _____

Group Number (if any): _____

Customer Service / Emergency Number: _____

_____

IN CASE OF EMERGENCY

Preferred Hospital: _____

Preferred ER (if known): _____

Notes for Medical Staff:

_____

_____

_____

_____

ADVANCE DIRECTIVES

Healthcare Proxy (Name): _____

Relationship: _____

Phone: _____

Living Will / Advance Directive: ☐ Yes ☐ No

Location / Notes: _____

Power of Attorney: ☐ Yes ☐ No

Location / Notes: _____

ADDITIONAL NOTES

_____

_____

_____

_____

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Parkinson's Emergency & Travel Pass

Print · Laminate · Carry Always

IMPORTANT

Show this card to any doctor,
paramedic, or hospital staff.
Your medication timing is critical.

This pass contains:

- Personal & emergency contacts
- Complete medication list
- Doctor contacts & insurance
- Symptoms for first responders

killparkinson.org

PARKINSON'S
EMERGENCY &
TRAVEL PASS

NAME

DATE OF BIRTH

BLOOD TYPE **DIAGNOSIS YEAR**

FOR FIRST RESPONDERS

I have Parkinson's disease. My movements,
speech or facial expression may appear unusual.
This is my condition — not intoxication.

EMERGENCY CONTACT

NAME & RELATIONSHIP

PHONE

Keep this card in your wallet at all times.

MY INFORMATION

Personal & Medical Details

PERSONAL DETAILS

FULL NAME

DATE OF BIRTH BLOOD TYPE

ADDRESS

PHONE

ALLERGIES (MEDICATIONS, FOOD, OTHER)

OTHER CONDITIONS

MY DOCTORS

MOVEMENT DISORDER SPECIALIST

PRACTICE / HOSPITAL PHONE

GP / PRIMARY CARE PHYSICIAN

PRACTICE PHONE

INSURANCE & TRAVEL

HEALTH INSURANCE PROVIDER & NUMBER

EUROPEAN HEALTH CARD NO. VALID UNTIL

TRAVEL INSURANCE PROVIDER & POLICY NO.

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Must Be Given ON TIME

CRITICAL — FOR HOSPITAL STAFF

Parkinson's medication MUST be given on time.
Delays of 30+ min can cause severe complications.
Do NOT withhold medication without neurologist approval.

DBS DEVICE

I have / do not have a Deep Brain Stimulator (DBS).
If YES: No MRI without prior neurosurgery clearance.

MEDICATION	DOSE	TIMES	NOTES

MEDICATION LIST

SYMPTOMS THAT MAY BE MISUNDERSTOOD

Freezing of gait
Sudden inability to move feet — not a fall risk behavior

Dysarthria
Slurred/quiet speech — I understand you fully

Hypomimia
Reduced facial expression — does not reflect mood

Dysphagia
Swallowing difficulties — adjust food/medication form

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DAILY MOTOR TRACKER

Track patterns. Improve treatment.

DATE: _____ / _____ / _____ DAY: _____

HOW TO USE

- Check one box per time block.
- Choose what describes the majority of that period.
- Consistency matters more than perfection.

- ☐ **ON** – good / normal mobility
- ☐ **ON + DYSKINESIA** – involuntary movements
- ☐ **OFF** – stiffness / slow / immobile
- ☐ **ASLEEP** – sleeping

AM / MORNING

TIME	ON	ON + DYSK	OFF	ASLEEP
12:00 - 1:00 AM	☐	☐	☐	☐
1:00 - 2:00 AM	☐	☐	☐	☐
2:00 - 3:00 AM	☐	☐	☐	☐
3:00 - 4:00 AM	☐	☐	☐	☐
4:00 - 5:00 AM	☐	☐	☐	☐
5:00 - 6:00 AM	☐	☐	☐	☐
6:00 - 7:00 AM	☐	☐	☐	☐
7:00 - 8:00 AM	☐	☐	☐	☐
8:00 - 9:00 AM	☐	☐	☐	☐
9:00 - 10:00 AM	☐	☐	☐	☐
10:00 - 11:00 AM	☐	☐	☐	☐
11:00 - 12:00 PM	☐	☐	☐	☐

PM / AFTERNOON & EVENING

TIME	ON	ON + DYSK	OFF	ASLEEP
12:00 - 1:00 PM	☐	☐	☐	☐
1:00 - 2:00 PM	☐	☐	☐	☐
2:00 - 3:00 PM	☐	☐	☐	☐
3:00 - 4:00 PM	☐	☐	☐	☐
4:00 - 5:00 PM	☐	☐	☐	☐
5:00 - 6:00 PM	☐	☐	☐	☐
6:00 - 7:00 PM	☐	☐	☐	☐
7:00 - 8:00 PM	☐	☐	☐	☐
8:00 - 9:00 PM	☐	☐	☐	☐
9:00 - 10:00 PM	☐	☐	☐	☐
10:00 - 11:00 PM	☐	☐	☐	☐
11:00 PM - 12:00 AM	☐	☐	☐	☐

NOTES / PATTERNS

When did OFF periods happen?

Any triggers?

Medication timing issues?

MEDICATION TIMING (QUICK LOG)

TIME	DOSE / MEDICATION

OTHER NOTES

PATTERNS CHANGE TREATMENT. **CONSISTENCY CREATES PATTERNS.**

PART 8

PARKINSON'S SYMPTOM TRACKER

DATE: _____

Track patterns. Not perfection.

1. OVERALL DAY RATING

Overall symptom load (1–5):

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Best period of the day: _____

Main challenge today: _____

Worst period of the day: _____

2. MOTOR SYMPTOMS

TREMOR

Severity (1–5):

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Side: ☐ Left ☐ Right ☐ Both

Notes: _____

RIGIDITY / STIFFNESS

☐ None ☐ Mild

☐ Moderate ☐ Severe

Where: _____

BRADYKINESIA (SLOWNESS)

☐ None ☐ Mild

☐ Moderate ☐ Severe

Affected tasks: _____

FREEZING EPISODES

☐ None ☐ 1–2

☐ 3–5 ☐ Frequent

Where / when: _____

BALANCE / STABILITY

☐ Stable

☐ Slight issues

☐ Unsteady

☐ High fall risk

FALLS / NEAR-FALLS

☐ None

☐ Near-fall

☐ Fall

Details: _____

DYSKINESIA

☐ None

☐ Mild

☐ Moderate

☐ Severe

When: _____

OTHER MOTOR SYMPTOMS

Please specify:

_____

_____

_____

3. NON-MOTOR SYMPTOMS

FATIGUE

☐ None ☐ Mild

☐ Moderate ☐ Severe

Pattern: _____

SLEEP (LAST NIGHT IMPACT)

☐ Good ☐ Fair

☐ Poor

Notes: _____

MOOD

☐ Stable ☐ Low

☐ Anxious ☐ Irritable

Trigger: _____

ANXIETY / STRESS

☐ None ☐ Mild

☐ Moderate ☐ High

Cause: _____

COGNITION / FOCUS

☐ Clear ☐ Slight difficulty

☐ Struggling

Examples: _____

MEMORY

☐ Normal

☐ Minor lapses

☐ Noticeable issues

APATHY / MOTIVATION

☐ None ☐ Mild

☐ Moderate ☐ Severe

OTHER NON-MOTOR SYMPTOMS

Please specify:

_____

_____

4. AUTONOMIC / BODY SYMPTOMS

CONSTIPATION / DIGESTION

☐ Normal

☐ Slow

☐ Difficult

Notes: _____

URINARY ISSUES

☐ None

☐ Urgency

☐ Frequency

☐ Incontinence

Notes: _____

BLOOD PRESSURE / DIZZINESS

☐ None

☐ Lightheaded

☐ Dizzy

☐ Near faint

Notes: _____

SWEATING / TEMPERATURE REG.

☐ Normal

☐ Increased

☐ Night sweats

Notes: _____

PAIN

☐ None

☐ Mild

☐ Moderate

☐ Severe

Type / location: _____

OTHER BODY SYMPTOMS (PLEASE SPECIFY)

_____

_____

_____

PART 8

5. SENSORY & PERCEPTUAL

SMELL
- ☐ Normal
- ☐ Reduced
- ☐ Absent

VISION / PERCEPTION
- ☐ Normal
- ☐ Blurry
- ☐ Depth issues
- ☐ Other: _____

HALLUCINATIONS / ILLUSIONS
- ☐ None
- ☐ Mild
- ☐ Frequent

Details: _____

SENSORY OVERLOAD
- ☐ None
- ☐ Mild
- ☐ High

Triggers: _____

OTHER SENSORY ISSUES
Please specify:

_____

_____

_____

6. SPEECH & SWALLOWING

SPEECH
☐ Normal ☐ Quiet / Soft ☐ Slurred ☐ Effortful

Notes: _____

SWALLOWING
☐ Normal ☐ Slight difficulty ☐ Choking risk

Notes: _____

7. MEDICATION EFFECT (OVERALL)

☐ Worked well ☐ Wearing off early ☐ Delayed onset ☐ Fluctuations ☐ Side effects

Notes: _____

_____

8. TRIGGERS & CONTEXT

STRESS LEVEL
- ☐ Low
- ☐ Medium
- ☐ High

WEATHER
☐ Neutral ☐ Heat ☐ Cold

☐ Humidity

☐ Other: _____

ACTIVITY LEVEL
- ☐ Low
- ☐ Moderate
- ☐ High

OTHER TRIGGERS (PLEASE SPECIFY)

_____

_____

_____

9. WHAT HELPED / WHAT MADE IT WORSE

WHAT HELPED TODAY?

_____

_____

_____

WHAT MADE IT WORSE?

_____

_____

_____

10. FREE NOTES

_____

_____

_____

_____

★ **Patterns matter more than single days.** Consistency turns experience into insight.

PART 8

MEDICATION PLAN & TRACKER – DAILY

DATE: _____

Stay on time. Stay in balance. Track your medications and how they work for you.

MON TUE WED THU FRI SAT SUN

1. DAILY MEDICATION SCHEDULE

TIME (e.g. 7:00 AM)	MEDICATION NAME (Brand / Generic)	DOSE (mg, mcg, etc.)	HOW TAKEN (1 tab, 1 cap, etc.)	WITH / WITHOUT FOOD	PLANNED TIME	ACTUAL TIME TAKEN	NOTES (e.g. with protein)
6:00 AM							
9:00 AM							
12:00 PM							
3:00 PM							
6:00 PM							
9:00 PM							
12:00 AM							
3:00 AM							
_____							

2. MEDICATION EFFECT TRACKER (For each main medication dose)

TIME TAKEN	MEDICATION (Name)	DOSE	KICKED IN (Time)	WORKING WELL? (1–5)	PEAK EFFECT (Time)	START WEARING OFF (Time)	WORE OFF (Time)	NOTES
				1 2 3 4 5				
				1 2 3 4 5				
				1 2 3 4 5				
				1 2 3 4 5				
				1 2 3 4 5				

3. SIDE EFFECTS TRACKER

TIME	MEDICATION (Name)	SIDE EFFECT (What happened?)	SEVERITY (1–5)	HOW LONG DID IT LAST?	WHAT HELPED?	NOTES

4. OTHER MEDICATIONS & SUPPLEMENTS (Daily)

TIME	MEDICATION / SUPPLEMENT (Name)	DOSE	REASON (Why taking)	NOTES

Set reminders. Use alarms. Stay consistent.

PART 8

MEDICATION RESPONSE TRACKER – DAILY

Precision matters. Timing is treatment.

DATE: _____

MON TUE WED THU FRI SAT SUN

MEDICATION / DOSE: _____ STRENGTH: _____

1 DOSE TIMING

Exact time each dose is taken.

TIME DOSE TAKEN: : ☐ AM ☐ PM

NOTES (if any): _____

2 "ON" RESPONSE

When medication starts working.

TIME "ON" BEGINS: : ☐ AM ☐ PM

DELAY (APPROX.): _____ min

WHAT I NOTICE WHEN IT "KICKS IN": _____

3 "OFF" PERIODS

When medication wears off.

TIME "OFF" BEGINS: : ☐ AM ☐ PM

SYMPTOMS RETURNING / WORSENING: _____

WHAT I NOTICE WHEN IT WEARS OFF: _____

4 DURATION

How long each dose lasts.

START OF EFFECT (ON): : ☐ AM ☐ PM

END OF EFFECT (OFF): : ☐ AM ☐ PM

TOTAL DURATION: _____ hrs

5 DYSKINESIA

Track when it occurs, how severe it is, and its impact.

WHEN DID IT occur? _____

(TIME / PERIOD): _____

SEVERITY: Mild ☐ Moderate ☐ Severe ☐

IMPACT ON DAILY FUNCTION:
- ☐ No impact
- ☐ Mild impact
- ☐ Moderate impact
- ☐ Severe impact

NOTES / DETAILS: _____

6 OVERALL MEDICATION EFFECT

How well did medication work today?

OVERALL RATING: (1 = Very poor 5 = Excellent)

1 2 3 4 5

NOTES / PATTERNS / ANYTHING IMPORTANT: _____

OTHER FACTORS THAT MAY HAVE INFLUENCED TODAY

(Check all that apply)

- ☐ Poor sleep
- ☐ Stress
- ☐ Illness
- ☐ High activity
- ☐ Low activity
- ☐ Diet changes
- ☐ Dehydration
- ☐ Weather
- ☐ Other: _____

ANYTHING ELSE TO NOTE? _____

Track the details. See the patterns.

Patterns guide adjustments. You guide your care.

Small logs. Big impact.

PART 8

SLEEP TRACKER

Track your sleep. Understand your patterns.

DATE: _____

NIGHT OVERVIEW

Time I went to bed: _____	Time lights out: _____	Time I woke up: _____	Hours slept: _____
Sleep quality: ☐ Poor ☐ Fair ☐ Good ☐ Great		Night disturbances (summary): _____	

SLEEP LOG – NIGHT TIME (Check all that apply for each time block)

TIME	ASLEEP	AWAKE	WOKE UP (Briefly)	WOKE UP (> 5 min)	BATHROOM	PAIN / DISCOMFORT	RLS / RESTLESS	NIGHT SWEATS	TROUBLE BREATHING	OTHER (Notes)
8:00 PM – 9:00 PM	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____
9:00 PM – 10:00 PM	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____
10:00 PM – 11:00 PM	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____
11:00 PM – 12:00 AM	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____
12:00 AM – 1:00 AM	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____
1:00 AM – 2:00 AM	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____
2:00 AM – 3:00 AM	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____
3:00 AM – 4:00 AM	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____
4:00 AM – 5:00 AM	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____
5:00 AM – 6:00 AM	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____
6:00 AM – 7:00 AM	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____
7:00 AM – 8:00 AM	☐	☐	☐	☐	☐	☐	☐	☐	☐	_____

EVENING / BEDTIME ROUTINE (Check all that apply)

- ☐ Exercise
- ☐ Screen time
- ☐ Alcohol
- ☐ Stretching / Yoga
- ☐ Reading
- ☐ Caffeine
- ☐ Meditation / Breathing
- ☐ Music
- ☐ Heavy meal late
- ☐ Hot shower / bath
- ☐ No routine
- ☐ Other: _____

NOTES ABOUT THE NIGHT

_____

_____

_____

_____

_____

_____

PART 8

MORNING & DAYTIME SUMMARY

Morning stiffness: ☐ None ☐ Mild ☐ Moderate ☐ Severe Duration: _____

First medication: _____

Time taken: _____

Kicked in at: _____

Mood on waking (1–5): _____

Energy level (1–5): _____

Bowel movement: ☐ Yes ☐ No

Notes: _____

DAYTIME NAPS

Did you nap today? ☐ Yes ☐ No

If yes, please log below.

NAP START TIME	NAP END TIME	DURATION	REFRESHED? (Yes / No)	NOTES
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	

FACTORS THAT MAY HAVE AFFECTED SLEEP

- ☐ Stress / Anxiety
- ☐ Illness / Infection
- ☐ Pain
- ☐ Medication change
- ☐ Too much caffeine
- ☐ Alcohol
- ☐ Late meal
- ☐ Travel / Time change
- ☐ Weather / Temperature
- ☐ Other: _____

SYMPTOMS IMPACTING SLEEP (Check all that apply)

- ☐ Tremor
- ☐ Stiffness
- ☐ Pain
- ☐ Restless legs
- ☐ Anxiety
- ☐ Urinary frequency
- ☐ Reflux / Heartburn
- ☐ Dream enactment
- ☐ Hallucinations
- ☐ Depression
- ☐ Other: _____

MEDICATION NOTES

Any medication taken at night or during the night?

_____

_____

_____

HOW DID YOUR SLEEP AFFECT YOUR DAY?

☐ Positively ☐ Neutral ☐ Negatively Notes: _____

NOTES / OBSERVATIONS

_____

_____

WEEKLY PATTERN SUMMARY (Optional – Look back at the week)

Best nights: _____

Worst nights: _____

What seems to help: _____

What seems to make it worse: _____

PART 8

MOOD TRACKER – DAILY

Track how you feel. Understand your patterns. Take control.

DATE: _____

MON TUE WED THU FRI SAT SUN

1. OVERALL MOOD TODAY

How would you rate your overall mood today?

1 2 3 4 5

(1 = Very low / 5 = Excellent)

Main emotion(s) today:

_____

_____

_____

Best part of your day:

_____

_____

Hardest part of your day:

_____

_____

2. MOOD THROUGHOUT THE DAY (Rate your mood at different times)

TIME	MOOD (1–5) 1 = Very low 5 = Excellent	ANXIETY (1–5) 1 = None 5 = Severe	IRRITABILITY (1–5) 1 = None 5 = Severe	ENERGY (1–5) 1 = Very low 5 = Very high	NOTES
Morning (6 AM – 12 PM)					
Afternoon (12 PM – 6 PM)					
Evening (6 PM – 10 PM)					
Night (10 PM – Bedtime)					

3. EMOTIONS & MENTAL WELL-BEING (Rate overall impact today)

- ☐ Calm / Peaceful
- ☐ Happy / Joyful
- ☐ Grateful
- ☐ Motivated
- ☐ Hopeful
- ☐ Anxious / Worried
- ☐ Sad / Down
- ☐ Irritable / Frustrated
- ☐ Lonely
- ☐ Stressed / Overwhelmed
- ☐ Flat / Numb
- ☐ Fearful
- ☐ Guilty / Shame
- ☐ Confused
- ☐ Other: _____

4. CAUSES & TRIGGERS

What may have influenced your mood today?

_____

_____

_____

Any specific triggers?

_____

_____

5. WHAT HELPED TODAY?

Things that improved your mood or mental well-being:

- ☐ Exercise / Movement
- ☐ Time outdoors / Sunlight
- ☐ Meditation / Breathing
- ☐ Music
- ☐ Spending time with others
- ☐ Reading / Hobbies
- ☐ Prayer / Spirituality
- ☐ Sleep / Rest
- ☐ Talking to someone
- ☐ Other: _____

Details:

_____

_____

_____

_____

6. LIFESTYLE FACTORS (Check all that apply)

Slept well last night	☐ Yes	☐ No	**Caffeine intake**	☐ Low	☐ Moderate	☐ High
Ate balanced meals	☐ Yes	☐ No	**Alcohol**	☐ Yes	☐ No	
Hydrated well	☐ Yes	☐ No	**Screen time**	☐ Low	☐ Moderate	☐ High

7. MEDICATION & MOOD

Did medication affect your mood today? ☐ Yes ☐ No

If yes, how? _____

_____

Any side effects that impacted your mood? ☐ Yes ☐ No

If yes, please describe: _____

_____

8. NOTES & REFLECTION

One thing I learned about myself today: _____

One thing I can do tomorrow to support my mood: _____

Other notes: _____

★ Your feelings matter. Tracking them is a step toward feeling better.

PART 8

HYDRATION TRACKER – DAILY

DATE: _____

Hydration fuels your body, supports your brain, and helps your meds work better.

MON TUE WED THU FRI SAT SUN

1. DAILY HYDRATION GOAL

Daily fluid goal:

_____ ml

(or _____ glasses)

Today's focus:

- ☐ Stay consistent
- ☐ Spread evenly
- ☐ Drink earlier in the day
- ☐ Other: _____

How would you rate your hydration today?

1 (Very low) 5 (Excellent)

Did you meet your goal?

- ☐ Yes
- ☐ Mostly
- ☐ No

If no, by how much? _____

2. FLUID INTAKE LOG

TIME	WHAT I DRANK	AMOUNT (ml / oz / cups)	GLASSES (✓)	HOW IT MADE ME FEEL (1–5)	NOTES
6 AM – 9 AM				1 2 3 4 5	
9 AM – 12 PM				1 2 3 4 5	
12 PM – 3 PM				1 2 3 4 5	
3 PM – 6 PM				1 2 3 4 5	
6 PM – 9 PM				1 2 3 4 5	
9 PM – Bedtime				1 2 3 4 5	
TOTAL		_____ ml	_____ glasses	Average: _____ / 5	

3. HYDRATION QUALITY

What was most of your fluid today?

- ☐ Water
- ☐ Sparkling water
- ☐ Tea / Herbal tea
- ☐ Coffee
- ☐ Milk / Plant milk
- ☐ Juice
- ☐ Electrolyte drink
- ☐ Other: _____

How would you rate the quality of your choices?
fluid choice:

1 (Poor) 5 (Excellent)

4. TIMING CHECK

Did you spread your fluids evenly?

- ☐ Yes
- ☐ Afternoon
- ☐ No

Did you drink enough earlier in the day?

- ☐ Yes
- ☐ Afternoon
- ☐ Night

Most of my fluids were: ☐ Morning ☐ Evening / Night

5. HOW DID MY HYDRATION AFFECT ME TODAY? (Rate 1–5)

Energy Level	Focus / Mental Clarity	Headaches	Dizziness / Lightheaded	Constipation / Digestion	Urination (Comfort)
1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5

Notes / Patterns:

6. HYDRATION CHALLENGES

What got in the way today?

- ☐ Forgot
- ☐ Too busy
- ☐ Not thirsty
- ☐ Bathroom concerns
- ☐ Wasn't accessible
- ☐ Other: _____

How can I make it easier tomorrow?

7. NOTES & REFLECTION

What worked well today?

What will I do differently tomorrow?

Anything I want to share with my doctor?

Small sips. Consistent habits. Big impact.

Hydrated today. Stronger tomorrow.

PART 8

NUTRITION TRACKER – DAILY

DATE: _____

Fuel your body. Support your brain. Optimize your day.

MON TUE WED THU FRI SAT SUN

1. TODAY'S NUTRITION GOALS

My goals for today:

- _____
- _____
- _____

Focus for today:

- ☐ More protein
- ☐ Better timing
- ☐ Hydration
- ☐ Fiber / Digestion
- ☐ Weight / Energy
- ☐ Other: _____

How did I fuel myself today?

(1 = Poor 3 = Okay 5 = Excellent)

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

2. MEALS & SNACKS

TIME	MEAL / SNACK	WHAT I ATE & DRANK (Be as specific as you can)	PROTEIN (g)	CARBS (g)	FAT (g)	FIBER (g)	CALORIES (approx.)	NOTES (Hunger? Fullness? Cravings?)
BREAKFAST								
LUNCH								
DINNER								
SNACKS / OTHERS								
DAILY TOTAL (approx.)		_____ g	_____ g	_____ g	_____ g	_____ kcal		

3. PROTEIN TIMING (Important for medication effectiveness)

MORNING (6 AM – 12 PM)
Protein: ☐ Yes ☐ No
Amount: _____ g

AFTERNOON (12 PM – 6 PM)
Protein: ☐ Yes ☐ No
Amount: _____ g

EVENING (6 PM – 9 PM)
Protein: ☐ Yes ☐ No
Amount: _____ g

NIGHT (9 PM – Bedtime)
Protein: ☐ Yes ☐ No
Amount: _____ g

Protein timing today was: ☐ Good ☐ Okay ☐ Not ideal Why? _____

4. HYDRATION (Glasses / ml)

Total today: _____ glasses / _____ ml

Water quality: ☐ Poor ☐ Okay ☐ Good ☐ Great

5. HUNGER & FULLNESS

How hungry was I before meals?
(1 = Not hungry 5 = Very hungry)
1 ○ 2 ○ 3 ○ 4 ○ 5 ○

How full was I after meals?
(1 = Not full 5 = Overly full)
1 ○ 2 ○ 3 ○ 4 ○ 5 ○

★ Good nutrition + good timing = better energy, better movement, better days.

PART 8

6. NUTRIENT QUALITY CHECK (Check all that apply)

PROTEIN	FIBER & PLANTS	HEALTHY FATS	MICRONUTRIENTS	ULTRA-PROCESSED FOODS
☐ Adequate protein	☐ 5+ servings fruits/veggies	☐ Omega-3 sources	☐ Colorful plate	☐ Minimal / None
☐ High-quality sources	☐ Good fiber intake	☐ Nuts / Seeds	☐ Variety of foods	☐ Some
☐ Spread throughout day	☐ Fermented foods	☐ Olive oil / Avocado	☐ Greens / Leafy veg	☐ More than usual
☐ Low today	☐ Low fiber today	☐ Low healthy fats	☐ Low variety	☐ Too much today
☐ Other: _____	☐ Other: _____	☐ Other: _____	☐ Other: _____	☐ Other: _____

7. WHAT MAY HAVE AFFECTED MY NUTRITION TODAY?

☐ Stress ☐ Busy day ☐ Poor sleep ☐ Low energy ☐ Emotional eating ☐ Social events

☐ Travel ☐ Not hungry ☐ Appetite changes ☐ Digestive issues ☐ Cravings ☐ Other: _____

Details: _____

8. DIGESTION & GUT

Digestion today:

☐ Great
☐ Good
☐ Poor
☐ Very poor

Any digestive issues?

☐ Yes ☐ No

If yes, what? _____

Bowel movement today?

☐ Yes (normal)
☐ Yes (not normal)
☐ No

Notes: _____

9. CRAVINGS & SATISFACTION

Did I have cravings today?

☐ Yes ☐ No

What did I crave? _____

Did I satisfy the cravings?

☐ Yes ☐ No ☐ Partly

How satisfied was I with my food choices today?
(1 = Not at all 5 = Very satisfied)

1 ○ 2 ○ 3 ○ 4 ○ 5 ○

What helped me make good choices today?

_____
_____
_____

What made it challenging?

_____
_____
_____

10. NOTES & REFLECTION

What went well with my nutrition today?	What will I do differently tomorrow?	One key thing I want to focus on:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Small choices today create big changes tomorrow. **Consistent > Perfect**

PART 8

NUTRITION & PROTEIN TRACKER – DAILY

Good nutrition. Smart timing. Better symptom control.

DATE: _____

MON TUE WED THU FRI SAT SUN

1. DAILY NUTRITION GOALS

- ☐ Eat balanced meals
- ☐ Stay hydrated
- ☐ Get enough protein
- ☐ Eat enough fiber
- ☐ Time protein around meds
- ☐ Reduce sugar / ultra-processed

Today's focus: _____

Did you meet your goals?

- ☐ Yes
- ☐ Mostly
- ☐ No

2. MEALS & SNACKS LOG

TIME	MEAL / SNACK	WHAT I ATE / DRANK (Details)	PROTEIN (g)	CARBS (g)	FAT (g)	FIBER (g)	PROTEIN TIMING (Relative to Meds)			HOW I FELT AFTER (1–5)
							Before	With	After	
Breakfast							☐	☐	☐	1 2 3 4 5
Snack							☐	☐	☐	1 2 3 4 5
Lunch							☐	☐	☐	1 2 3 4 5
Snack							☐	☐	☐	1 2 3 4 5
Dinner							☐	☐	☐	1 2 3 4 5
Evening Snack							☐	☐	☐	1 2 3 4 5
DAILY TOTAL										Average: ____ / 5

3. PROTEIN TIMING CHECK

Did you space protein away from your medication?

- ☐ Yes (Good timing)
- ☐ Somewhat
- ☐ No (Too close)

Notes / What I noticed: _____

4. NUTRITION QUALITY

How would you rate the quality of your nutrition today?

☆ ☆ ☆ ☆ ☆

1 (Poor) 5 (Excellent)

How balanced were your meals?

- ☐ Poor
- ☐ Fair
- ☐ Gain
- ☐ Pair
- ☐ Very Good
- ☐ Excellent

Notes: _____

5. HOW DID MY NUTRITION AFFECT ME TODAY? (Rate 1–5)

Energy Level	Focus / Mental Clarity	Blood Sugar Stability
1 2 3 4 5	1 2 3 4 5	1 2 3 4 5

Digestive Comfort	Mood / Emotional Well-Being	Motor Symptoms (Overall Impact)
1 2 3 4 5	1 2 3 4 5	1 2 3 4 5

Notes / Patterns: _____

6. NUTRITION CHALLENGES

What got in the way today?

- ☐ Not enough time
- ☐ Low appetite
- ☐ Travel / Out
- ☐ Cravings
- ☐ Digestive issues
- ☐ Other: _____

How will I improve tomorrow?

_____

7. NOTES & REFLECTION

What worked well today?

What will I do differently tomorrow?

Anything I want to share with my doctor?

Nourish your body. Time your protein. Support your movement.

PART 8

WEIGHT TRACKER – DAILY

DATE: _____

Track the trend. Not just the number.

MON TUE WED THU FRI SAT SUN

1. TODAY'S WEIGHT

Today's weight

_____ kg

_____ lbs

Time of day

- ☐ Morning (after bathroom)
- ☐ Evening
- ☐ Other: _____

How does this compare?

Compared to yesterday

☐ Lower ☐ Same ☐ Higher

Compared to last week

☐ Lower ☐ Same ☐ Higher

2. WEIGHT TREND LOG

DATE	WEIGHT (kg)	WEIGHT (lbs)	TIME OF DAY	CHANGE (vs. yesterday)	NOTES (e.g., clothing, bloating, illness)
				☐ ↓ ☐ → ☐ ↑	
				☐ ↓ ☐ → ☐ ↑	
				☐ ↓ ☐ → ☐ ↑	
				☐ ↓ ☐ → ☐ ↑	
				☐ ↓ ☐ → ☐ ↑	
				☐ ↓ ☐ → ☐ ↑	
				☐ ↓ ☐ → ☐ ↑	
				☐ ↓ ☐ → ☐ ↑	

3. WEEKLY SUMMARY

Average weight this week

_____ kg

_____ lbs

Lowest weight

_____ kg

Date: _____

Highest weight

_____ kg

Date: _____

Weight change this week

_____ kg

☐ Gain ☐ Loss ☐ No change

4. FACTORS THAT MAY HAVE AFFECTED MY WEIGHT THIS WEEK (Check all that apply)

- ☐ Diet / Calorie intake
- ☐ Protein intake
- ☐ Hydration
- ☐ Exercise / Activity
- ☐ Constipation / Bowel changes
- ☐ Sleep quality
- ☐ Stress
- ☐ Illness / Infection
- ☐ Medication changes
- ☐ Fluid retention / Bloating
- ☐ Alcohol
- ☐ Other: _____

5. NOTES & REFLECTION

What worked well this week?

_____

_____

_____

What will I do differently next week?

_____

_____

_____

Anything to share with my doctor?

_____

_____

_____

★ Focus on progress, not perfection. Small changes lead to big results.

SAFETY TRACKER - DAILY

DATE: ____________

MON TUE WED THU FRI SAT SUN

Track near-falls, falls, and safety concerns to prevent future incidents.

1. TODAY'S OVERALL SAFETY

How would you rate your overall safety today?
(1 = Very unsafe 5 = Very safe)

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Safety summary in one word: ____________

Notes: ____________

2. INCIDENT LOG

Record any safety incidents, near-falls, or falls.

TIME	TYPE (Fall / Near-fall / Unsafe Moment)	LOCATION (Where it happened)	WHAT HAPPENED? (Brief description)	INJURY? (Y / N)	SEVERITY (1 = Low 5 = High)	ACTIVITY (What you were doing)
: :	☐ Fall ☐ Near-fall ☐ Unsafe moment			☐ Yes ☐ No	1 2 3 4 5	
: :	☐ Fall ☐ Near-fall ☐ Unsafe moment			☐ Yes ☐ No	1 2 3 4 5	
: :	☐ Fall ☐ Near-fall ☐ Unsafe moment			☐ Yes ☐ No	1 2 3 4 5	
: :	☐ Fall ☐ Near-fall ☐ Unsafe moment			☐ Yes ☐ No	1 2 3 4 5	
: :	☐ Fall ☐ Near-fall ☐ Unsafe moment			☐ Yes ☐ No	1 2 3 4 5	

3. TRIGGERS & FACTORS

What may have contributed to the incident?

- ☐ Fatigue / Low energy
- ☐ Dizziness / Lightheaded
- ☐ Medication side effects
- ☐ Pain / Discomfort
- ☐ Rushed / Distracted
- ☐ Poor lighting
- ☐ Clutter / Mess
- ☐ Uneven surface
- ☐ Weather conditions
- ☐ Mobility / Balance issue
- ☐ Vision issues
- ☐ Footwear issue
- ☐ Other: ____________

4. SAFETY PATTERNS

Where do incidents happen most often?

- ☐ Home - Bathroom
- ☐ Home - Bedroom
- ☐ Home - Kitchen
- ☐ Home - Stairs
- ☐ Home - Living Room
- ☐ Outside
- ☐ Work / School
- ☐ Other: ____________

When do incidents happen most often?

- ☐ Morning (6 AM - 12 PM)
- ☐ Afternoon (12 PM - 6 PM)
- ☐ Evening (6 PM - 10 PM)
- ☐ Night (10 PM - 6 AM)

What patterns have you noticed?

____

5. PREVENTION & ACTION PLAN

What could help prevent incidents?

____

What will you do differently?

____

Who can support you?

- ☐ No one
- ☐ Family / Partner
- ☐ Friend
- ☐ Caregiver
- ☐ Other: ____________

6. TODAY'S SAFETY CHECK

Did you feel safe in your environment today?

☐ Yes ☐ Somewhat ☐ No ☐ Unsure

Did you take any safety precautions? ☐ Yes ☐ No

☐ Yes ☐ No If yes, what? ____________

7. NOTES & REFLECTION

Anything else to note about today's safety?

____

Awareness today. Prevention tomorrow. | Your safety matters. | Small steps. Safer days.

PART 8

TRIGGER TRACKER

Understand your context. Recognize your patterns. Reduce your triggers.

DATE: _____

DAY: _____

MON TUE WED THU FRI SAT SUN

1. OVERALL TRIGGER LOAD TODAY

How would you rate your overall trigger load today?
(1 = Very low 5 = Very high)

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Notes / anything that stood out?

_____

_____

_____

2. TRIGGER CATEGORIES

Track the key areas that may influence your symptoms.

STRESS LEVEL

How stressful was today?
(1 = Very low 5 = Very high)

1 2 3 4 5
○ ○ ○ ○ ○
1 2 3 4 5

Main stress source(s):

- ☐ Health
- ☐ Relationships
- ☐ Work / School
- ☐ Care responsibilities
- ☐ Finances
- ☐ Other: _____

Notes:

_____

SLEEP QUALITY (LAST NIGHT)

How was your sleep quality?
(1 = Very poor 5 = Excellent)

1 2 3 4 5
○ ○ ○ ○ ○

Hours slept: _____ h _____ min

Fell asleep easily?
☐ Yes ☐ No ☐ Sometimes

Woke up during the night?
☐ Yes ☐ No ☐ Sometimes

How rested do you feel?
(1 = Not at all 5 = Very rested)

1 2 3 4 5
○ ○ ○ ○ ○

WEATHER CONDITIONS

Weather today:

- ☐ Sunny
- ☐ Partly cloudy
- ☐ Cloudy
- ☐ Rainy
- ☐ Stormy
- ☐ Snowy
- ☐ Foggy / Humid

Other: _____

Temperature: _____ °C / °F

Humidity: _____ %

Pressure (if known): _____ hPa

How did the weather affect you?
(1 = Very negative 5 = Very positive)

1 2 3 4 5
○ ○ ○ ○ ○

SOCIAL SITUATION

How was your social day?
(1 = Very difficult 5 = Very easy)

1 2 3 4 5
○ ○ ○ ○ ○

Main social context:

- ☐ Alone / Isolated
- ☐ Small group
- ☐ Large group
- ☐ Crowded places
- ☐ Social event
- ☐ Work / Obligations
- ☐ Family time
- ☐ Other: _____

How did it affect you?
(1 = Very negative 5 = Very positive)

1 2 3 4 5

PHYSICAL ACTIVITY

Activity level today:
(1 = Very low 5 = Very high)

1 2 3 4 5
○ ○ ○ ○ ○

Type of activity:

- ☐ Walking
- ☐ Exercise / Workout
- ☐ Housework / Chores
- ☐ Physical therapy
- ☐ Active day
- ☐ Sedentary day
- ☐ Other: _____

How did it affect you?
(1 = Very negative 5 = Very positive)

1 2 3 4 5
○ ○ ○ ○ ○

NUTRITION & HYDRATION

How was your nutrition today?
(1 = Very poor 5 = Excellent)

1 2 3 4 5
○ ○ ○ ○ ○

Hydration:
(1 = Very low 5 = Very high)

1 2 3 4 5
○ ○ ○ ○ ○

Notable triggers:

- ☐ Caffeine
- ☐ Alcohol
- ☐ Sugar / Sweets
- ☐ High salt
- ☐ Processed food
- ☐ Skipped meals
- ☐ Dehydration
- ☐ Other: _____

Notes:

_____

MEDICATION & TREATMENTS

Any changes today?
☐ Yes ☐ No

Medication taken as usual?
☐ Yes ☐ No

New medication / dose change?
☐ Yes ☐ No

Missed medication?
☐ Yes ☐ No

Treatments / Therapy today?
☐ Yes ☐ No

Notes:

_____

_____

ENVIRONMENT

How was your environment today?
(1 = Very poor 5 = Excellent)

1 2 3 4 5
○ ○ ○ ○ ○

Check all that apply:

- ☐ Too noisy
- ☐ Too bright
- ☐ Too hot
- ☐ Too cold
- ☐ Poor air quality
- ☐ Cluttered
- ☐ Uncomfortable places
- ☐ Other: _____

How did it affect you?
(1 = Very negative 5 = Very positive)

1 2 3 4 5
○ ○ ○ ○ ○

3. OTHER POSSIBLE TRIGGERS

Anything else that may have influenced your symptoms today?

_____

_____

_____

_____

4. TRIGGER IMPACT SUMMARY

Which triggers had the biggest impact today?

1. _____
2. _____
3. _____

Overall impact on symptoms:
(1 = Very negative 5 = Very positive)

1 2 3 4 5
○ ○ ○ ○ ○

Notes:

_____

5. PATTERNS & INSIGHTS

What patterns do you notice?

_____

_____

_____

What helps reduce your triggers?

_____

_____

_____

What will you focus on tomorrow?

_____

_____

_____

Awareness creates choice. | Patterns create power. | Small changes. Big difference.

BOWEL TRACKER – DAILY

matters. Your comfort matters.

DATE: ____________________

MON TUE WED THU FRI SAT SUN

1. BOWEL MOVEMENT LOG

DATE	TIME (e.g., 8:00 AM)	TYPE (Bristol Stool Scale)	EFFORT (1 = Easy, 5 = Very hard)	COMPLETE EVACUATION?	FEELING AFTER	NOTES / TRIGGERS
		1 2 3 4 5 6 7	1 2 3 4 5	☐ Yes ☐ No	☺ ☺ ☹	
		1 2 3 4 5 6 7	1 2 3 4 5	☐ Yes ☐ No	☺ ☺ ☹	
		1 2 3 4 5 6 7	1 2 3 4 5	☐ Yes ☐ No	☺ ☺ ☹	
		1 2 3 4 5 6 7	1 2 3 4 5	☐ Yes ☐ No	☺ ☺ ☹	
		1 2 3 4 5 6 7	1 2 3 4 5	☐ Yes ☐ No	☺ ☺ ☹	
		1 2 3 4 5 6 7	1 2 3 4 5	☐ Yes ☐ No	☺ ☺ ☹	
		1 2 3 4 5 6 7	1 2 3 4 5	☐ Yes ☐ No	☺ ☺ ☹	
		1 2 3 4 5 6 7	1 2 3 4 5	☐ Yes ☐ No	☺ ☺ ☹	

2. BRISTOL STOOL SCALE GUIDE

1		Separate hard lumps, like nuts (hard to pass)
2		Sausage-shaped but lumpy
3		Like a sausage or snake, with cracks on the surface
4		Like a sausage or snake, smooth and soft
5	(soft blobs)	Soft blobs with clear-cut edges (easy to pass)
6	(mushy)	Fluffy pieces with ragged edges, mushy
7	(watery)	Watery, no solid pieces, entirely liquid

3. TODAY'S BOWEL SUMMARY

Did you have a bowel movement today? ☐ Yes ☐ No

How would you rate your overall bowel comfort today?

1 2 3 4 5

(1 = Very uncomfortable 5 = Very comfortable)

Any bloating or gas?

☐ None ☐ Mild ☐ Moderate ☐ Severe

Any pain or cramping?

☐ None ☐ Mild ☐ Moderate ☐ Severe

Comments: ____________________

4. SUPPORTS & STRATEGIES (Check all that apply)

☐ Water / Fluids
☐ High fiber foods
☐ Fruits
☐ Vegetables

☐ Prunes / Raisins
☐ Whole grains
☐ Probiotics
☐ Magnesium

☐ Stool softener
☐ Laxative
☐ Fiber supplement
☐ Other: __________

Other things that helped:

5. NOTES & PATTERNS

What seems to help mesy regular?

What makes constipation worse?

Anything to tell my doctor?

Listening to your body helps you stay ahead. You are in control.

PART 8

ENERGY & COGNITIVE LOAD TRACKER – DAILY

DATE: _____

Track your energy patterns and mental load. Understand your rhythms. Protect your energy.

MON TUE WED THU FRI SAT SUN

1. OVERALL ENERGY TODAY

How would you rate your overall energy today?

(1 = Very low 5 = Very high)

1 2 3 4 5

What best describes your energy today?

- ☐ Very low / Drained
- ☐ Low
- ☐ Moderate
- ☐ Good
- ☐ High / Energized

What influenced your energy the most today?

_____

_____

_____

_____

2. ENERGY LEVEL THROUGHOUT THE DAY

Rate your energy at different times.

TIME BLOCK	ENERGY LEVEL (1–5) 1 = Very low 5 = Very high	PHYSICAL ENERGY (Body) 1–5	MENTAL ENERGY (Mind) 1–5	NOTES (What was happening?)
MORNING (6 AM - 10 AM)	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	
LATE MORNING (10 AM - 1 PM)	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	
AFTERNOON (1 PM - 4 PM)	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	
EVENING (4 PM - 8 PM)	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	
NIGHT (8 PM - Bedtime)	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	

3. ENERGY CRASHES & PEAKS

When did you feel your energy peak today?

Time: _____

What were you doing?

_____

_____

_____

When did you experience an energy crash?

Time(s): _____

What were you doing?

_____

What do you think triggered it?

_____

4. ENERGY SUPPORT

What helped you maintain or boost your energy today?

- ☐ Rest / Breaks
- ☐ Hydration
- ☐ Good nutrition
- ☐ Movement / Exercise
- ☐ Fresh air / Sunlight
- ☐ Positive mindset
- ☐ Social connection
- ☐ Meditation / Breathing
- ☐ Music
- ☐ Other: _____

5. ENERGY NOTES & REFLECTION

What worked well for your energy today?

_____

_____

_____

What drained your energy?

_____

_____

_____

What will you do differently tomorrow?

_____

_____

_____

Protect your energy today, so you can show up tomorrow.

PART 8

6. COGNITIVE LOAD TODAY

How would you rate your overall cognitive load today?

(1 = Very light 5 = Overwhelming)

1 2 3 4 5

What best describes your mental load?

- ☐ Very light / Easy
- ☐ Light
- ☐ Moderate
- ☐ High
- ☐ Overwhelming

What influenced your cognitive load the most today?

_____

_____

_____

_____

7. COGNITIVE LOAD THROUGHOUT THE DAY

Rate your mental/cognitive load at different times.

TIME BLOCK	COGNITIVE LOAD (1–5) 1 = Very light 5 = Overwhelming	FOCUS & CLARITY (1–5) 1 = Poor 5 = Excellent	MENTAL FATIGUE (1–5) 1 = None 5 = Extreme	NOTES (What was happening?)
MORNING (6 AM – 10 AM)	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	
LATE MORNING (10 AM – 1 PM)	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	
AFTERNOON (1 PM – 4 PM)	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	
EVENING (4 PM – 8 PM)	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	
NIGHT (8 PM – Bedtime)	1 2 3 4 5	1 2 3 4 5	1 2 3 4 5	

8. COGNITIVE LOAD DRIVERS

What increased your cognitive load today? (Check all that apply)

- ☐ Too many tasks / To-do list
- ☐ Time pressure / Deadlines
- ☐ Multitasking
- ☐ Complex decisions
- ☐ Learning something new
- ☐ Distractions (noise, phone, etc.)
- ☐ Social interactions
- ☐ Changes in plans
- ☐ Uncertainty
- ☐ Other: _____

9. WHAT HELPED REDUCE MENTAL LOAD?

What helped you reduce or manage your cognitive load today?

- ☐ Planning / Prioritizing
- ☐ Taking breaks
- ☐ Saying no / Setting boundaries
- ☐ Mindfulness / Meditation
- ☐ Simplifying tasks
- ☐ Delegating / Asking for help
- ☐ Routine / Structure
- ☐ Focus time (no distractions)
- ☐ Good sleep
- ☐ Other: _____

10. COGNITIVE LOAD NOTES & REFLECTION

What worked well for your mind today?

_____

_____

_____

What overwhelmed you?

_____

_____

_____

What will you do differently tomorrow?

_____

_____

_____

A calm mind has more clarity, makes better decisions, and protects your energy.

PART 8

SOCIAL & ISOLATION TRACKER - DAILY

Connection fuels well-being. Track your social interactions and feelings of connection.

DATE: _____

MON TUE WED THU FRI SAT SUN

1. TODAY'S SOCIAL GOAL

My social goal for today:

_____

_____

_____

How important is connection to you today? (1 = Not important 5 = Very important)

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

Did you meet your goal?

☐ Yes ☐ Partly ☐ No

Why or why not?

_____

2. SOCIAL INTERACTIONS LOG

List your interactions, no matter how small.

TIME	WHO WAS IT WITH? (Name / Relationship)	TYPE OF INTERACTION (see guide below)	IN PERSON	VIRTUAL / PHONE	DURATION (approx.)	HOW ENJOYABLE WAS IT? (1 = Not at all 5 = Very much)	NOTES (What stood out?)
MORNING (6 AM - 12 PM)			☐	☐	_____	1 2 3 4 5	
AFTERNOON (12 PM - 6 PM)			☐	☐	_____	1 2 3 4 5	
EVENING (6 PM - 10 PM)			☐	☐	_____	1 2 3 4 5	
NIGHT (10 PM - Bedtime)			☐	☐	_____	1 2 3 4 5	

TYPE OF INTERACTION GUIDE (Examples)

- **Conversation** — Talking, chatting, deep talk
- **Quality Time** — Spending time together, activities
- **Practical / Support** — Helping / getting help, errands, support
- **Group / Community** — Group activity, class, meeting, event
- **Online / Social Media** — Social media, messages, online communities
- **Other** — Other interactions

3. FEELINGS OF CONNECTION

How connected did you feel today?

(1 = Not connected at all 5 = Very connected)

○ 1 ○ 2 ○ 3 ○ 4 ○ 5

What best describes your overall feeling of connection today?

- ☐ Very connected
- ☐ Connected
- ☐ Neutral
- ☐ Somewhat isolated
- ☐ Very isolated

- ☐ Positive interactions
- ☐ Quality time
- ☐ Helping others
- ☐ Feeling understood
- ☐ Lack of interactions

connection the most today?

- ☐ Loneliness
- ☐ Stress / Mood
- ☐ Health / Energy
- ☐ Other: _____

4. IMPACT ON MY DAY

Rate the impact of social connection on the following areas today.

MOOD	ENERGY	MOTIVATION	MENTAL CLARITY	OVERALL WELL-BEING
-2 -1 0 +1 +2	-2 -1 0 +1 +2	-2 -1 0 +1 +2	-2 -1 0 +1 +2	-2 -1 0 +1 +2
○ ○ ○ ○ ○	○ ○ ○ ○ ○	○ ○ ○ ○ ○	○ ○ ○ ○ ○	○ ○ ○ ○ ○

Connection doesn't need to be big to be powerful. Small moments matter.

PART 8

ENVIRONMENTAL & EXTERNAL FACTORS

These explain fluctuations doctors can't see.

DATE: _____

MON TUE WED THU FRI SAT SUN

1. WEATHER

General weather today:

Sunny | Partly cloudy | Cloudy | Rainy | Stormy | Snowy

_____

Temperature (°C / °F)

_____ °C / °F

Humidity (%)

_____ %

How did the weather affect you today?

(1 = Very negative 5 = Very positive)

1 2 3 4 5

Notes / Impact:

_____

_____

_____

2. STRESS

Overall stress level today:

(1 = Very low 5 = Very high)

1 2 3 4 5

Notes / Details:

_____

_____

Key stressors today:

- ☐ Work / School _____
- ☐ Health concerns _____
- ☐ Finances _____
- ☐ Relationships _____
- ☐ Care responsibilities _____
- ☐ Time pressure / Deadlines _____
- ☐ Other: _____

3. SOCIAL INTERACTION

How would you describe your social day?

(1 = Very isolated 5 = Very connected)

1 2 3 4 5

Today I was mostly:

Alone / Isolated | Some Interaction | Well Connected

Who did you interact with?

(Check all that apply)

- ☐ Family
- ☐ Partner
- ☐ Friends
- ☐ Colleagues
- ☐ Neighbors
- ☐ Support group / Community
- ☐ Other: _____

How did social interaction impact you today?

(1 = Very negative 5 = Very positive)

1 2 3 4 5

Notes / Impact:

_____

_____

_____

OVERALL IMPACT SUMMARY

How did today's environment & external factors affect your overall well-being?

(1 = Very negative 5 = Very positive)

1 2 3 4 5

Key takeaways / patterns I notice:

_____

_____

_____

Track the unseen. Understand the patterns.

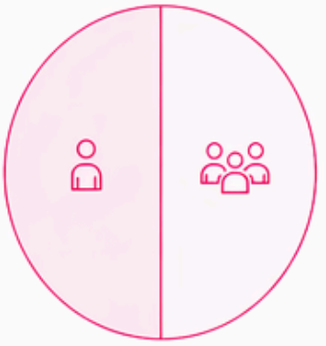
Awareness brings clarity. Clarity brings control.

Small insights. Big impact.

PART 8

5. TIME SPENT ALONE VS. WITH OTHERS

How was your day balanced?



Time spent alone (approx.) _____ hrs

Time spent with others (approx.) _____ hrs

Total waking hours: _____ hrs

How did the balance feel today?

- ☐ Too much alone time
- ☐ About right
- ☐ Too much social time
- ☐ Felt unbalanced
- ☐ Other: _____

Comments:

_____

6. BARRIERS TO CONNECTION

What got in the way of more connection today? (Check all that apply)

- ☐ Fatigue / Low energy
- ☐ Physical symptoms
- ☐ Mood / Anxiety / Depression
- ☐ Lack of motivation
- ☐ Time constraints
- ☐ Transportation / Mobility
- ☐ Social anxiety
- ☐ Not feeling up to it
- ☐ Technology challenges
- ☐ No one available
- ☐ Other: _____
- ☐ None

What could help reduce these barriers tomorrow?

_____

_____

_____

_____

7. SOCIAL SUPPORT CHECK

Do you feel you have enough support?

☐ Yes ☐ Somewhat ☐ No ☐ Unsure

Who are your main support people?

_____

Did you reach out for support today?

☐ Yes ☐ No

If yes, how did it go?

☐ Helpful ☐ Somewhat helpful ☐ Not helpful

Notes: _____

8. QUALITY OVER QUANTITY

What made any interactions meaningful today?

_____

_____

What could make tomorrow more meaningful?

_____

_____

9. NOTES & REFLECTION

What went well socially today?

_____

_____

_____

What was challenging?

_____

_____

_____

What will you do differently tomorrow?

_____

_____

_____

You are not alone in this. Connection is a strength, not a weakness.

PART 8

DATE: _____ DAY: _____ MONTH: _____ YEAR: _____

MOOD (1–5): ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 | ENERGY (1–5): ○ 1 ○ 2 ○ 3 ○ 4 ○ 5

TODAY I NOTICED:

WHAT MATTERED MOST TODAY:

ONE THING I WANT TO REMEMBER:

 SMALL MOMENTS. REAL INSIGHT. | CONSISTENCY CREATES CLARITY. | 

EXERCISE TRACKER – DAILY

DATE: _____

Movement is medicine. Track your activity, how it felt, and the impact.

MON TUE WED THU FRI SAT SUN

1. OVERALL ACTIVITY SUMMARY

Did you exercise today?
☐ Yes ☐ No

If yes, how many sessions?
☐ 1 ☐ 2 ☐ 3 ☐ 4+

Total exercise time:
_____ minutes

How would you rate your overall activity level today?
(1 = very low 5 = very high)
☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

2. EXERCISE SESSIONS

SESSION (1, 2, 3…)	TYPE OF EXERCISE (see examples below)	START TIME	DURATION (min)	INTENSITY (1–5)	RPE* (1–10)	HOW IT FELT (before / during / after)	NOTES
1							
2							
3							
4							

*RPE = Rate of Perceived Exertion (1 = very easy 10 = maximal effort)

EXERCISE TYPES (Examples)

- ☐ Aerobic (walking, cycling, dance, swimming, cardio)
- ☐ Strength / Resistance (weights, bands, machines, bodyweight)
- ☐ Flexibility / Stretching (yoga, stretching, mobility)
- ☐ Balance / Stability (Tai Chi, balance drills, core work)
- ☐ Boxing / PD-specific (Boxing, PWR!, Rock Steady, etc.)
- ☐ Other: _____

INTENSITY GUIDE (1–5)

1 = Very light (easy movement)
2 = Light
3 = Moderate (noticeable effort)
4 = Hard
5 = Very hard (challenging)

RPE GUIDE (1–10)

1–2 = Very easy
3–4 = Easy
5–6 = Moderate
7–8 = Hard
9–10 = Very hard

3. BENEFITS & IMPACT

Energy level after exercise	☐ 1 (low)	☐ 2	☐ 3	☐ 4	5 (high)
Mood after exercise	☐ 1 (worse)	☐ 2	☐ 3	☐ 4	5 (better)
PD symptoms after exercise	☐ 1 (worse)	☐ 2	☐ 3	☐ 4	5 (better)
Sleep quality (last night)	☐ 1 (worse)	☐ 2	☐ 3	☐ 4	5 (better)
Overall sense of well-being	☐ 1 (low)	☐ 2	☐ 3	☐ 4	5 (high)

WHAT IMPROVED AFTER EXERCISE? (Check all that apply)

☐ Mobility ☐ Balance ☐ Strength ☐ Stiffness
☐ Mood ☐ Energy ☐ Focus ☐ Sleep
☐ Other: _____

WHAT WAS CHALLENGING?

_____
_____

4. ADDITIONAL FACTORS

Fluid intake today (glasses): _____

Protein timing OK?
☐ Yes ☐ No

Medications taken on time?
☐ Yes ☐ No

Pain during exercise?
☐ None ☐ Mild
☐ Moderate ☐ Severe

Any dizziness or lightheadedness?
☐ Yes ☐ No
Details: _____

5. FALLS OR NEAR-FALLS

☐ None ☐ Yes

Describe: _____
_____

6. NOTES & REFLECTION

Best part of today: _____

One thing to tell my doctor: _____
_____

★ Consistency creates progress. Every move counts.

PART 8

NOTES

CAPTURE. CLARIFY. MOVE FORWARD.

DATE: _____ DAY: _____ WEEK: _____

NOTES & THOUGHTS

WHAT STOOD OUT TODAY?

ANY SYMPTOM CHANGES?

ANYTHING UNUSUAL?

POSSIBLE TRIGGERS

(STRESS, SLEEP, FOOD, ETC.)

WHAT HELPED?

FOR MY DOCTOR

QUESTIONS / THINGS TO MENTION

FOLLOW-UP / ACTIONS

WHAT I WANT TO TRY OR CHANGE

SMALL DETAILS MATTER. | PATTERNS START HERE.