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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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

_____

_____

_____

_____

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

MOOD TRACKER – WEEKLY OVERVIEW

WEEK OF: _____

1. WEEKLY MOOD SUMMARY

How would you rate your overall week?

1 2 3 4 5

(1 = Very low / 5 = Excellent)

Best day this week: _____

Why? _____

Hardest day this week: _____

Why? _____

Main emotions this week: _____

2. DAILY MOOD OVERVIEW (Rate your overall mood)

DAY	MON	TUE	WED	THU	FRI	SAT	SUN	WEEK AVERAGE
MOOD (1–5) 1 = Very low 5 = Excellent								
ANKIETY (1–5) 1 = None 5 = Severe								
IRRITABILITY (1–5) 1 = None 5 = Severe								
ENERGY (1–5) 1 = Very low 5 = Very high								
NOTES / HIGHLIGHTS								

3. PATTERNS & INSIGHTS

What patterns do you notice in your mood this week?

What may have influenced your mood (triggers or positive factors)?

What worked well for you this week?

What was challenging?

4. LIFESTYLE & WELL-BEING SUMMARY

SLEEP QUALITY (Average)

- ☐ Poor
- ☐ Fair
- ☐ Good
- ☐ Excellent

EXERCISE / MOVEMENT

(Days this week)

☐ 1 2 3 4 5 6 7

SOCIAL CONNECTION

(This week)

- ☐ Low
- ☐ Moderate
- ☐ High

STRESS LEVEL (Average)

- ☐ Low
- ☐ Moderate
- ☐ High
- ☐ Very High

NOTES

5. MEDICATION & MOOD REVIEW

Any changes in medication this week?

☐ Yes ☐ No

Details: _____

Did medication affect your mood or emotions this week?

☐ Yes ☐ No

If yes, how? _____

Any side effects that impacted your mood?

☐ Yes ☐ No

If yes, describe: _____

6. LOOKING AHEAD

One goal for next week to support my mood: _____

One thing I will continue doing: _____

One thing I will try doing differently: _____

★ Awareness creates choice. Choice creates change.

Bring this to your doctor appointment.

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 / Lighthead
- ☐ 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.

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.

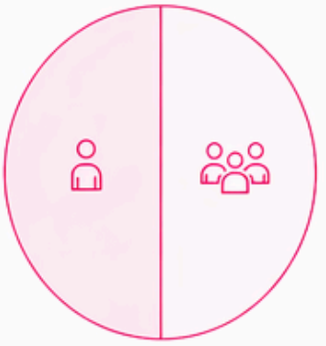
Awareness brings clarity. Clarity brings control.

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. 

PART 8

WEEKLY REFLECTION & PATTERN SHEET

Review. Learn. Adjust. Improve.

WEEK OF: _____

MON TUE WED THU FRI SAT SUN

1. WEEK OVERVIEW – HOW DID IT GO?

Overall week rating (1 = Very difficult 5 = Excellent)

○ ○ ○ ○ ○

1 2 3 4 5

This week in 3 words:

★ _____

★ _____

★ _____

2. BIG WINS – WHAT WENT WELL?

What are you proud of this week?

- _____
- _____
- _____
- _____
- _____

3. BIGGEST CHALLENGES

What was most difficult this week?

1. _____
2. _____
3. _____

4. PATTERNS & INSIGHTS

What patterns did you notice in your:

SYMPTOMS	ENERGY	SLEEP	MOOD	MEDICATION	ACTIVITY

5. TOP 3 FACTORS THAT HAD THE BIGGEST IMPACT THIS WEEK

Rank what influenced you the most (1 = Biggest impact)

- ☐ Sleep quality ____
- ☐ Stress level ____
- ☐ Medication timing / Effectiveness ____
- ☐ Exercise / Physical activity ____
- ☐ Nutrition / Protein timing ____
- ☐ Hydration ____
- ☐ Weather ____
- ☐ Social interactions / Connection ____
- ☐ Bowel / Digestion ____
- ☐ Pain / Discomfort ____
- ☐ Mental load / Overwhelm ____
- ☐ Other: _____ ____

6. WHAT HELPED THE MOST?

What had the most positive impact?

- _____
- _____
- _____
- _____

Keep doing more of:

1. _____
2. _____
3. _____

7. WHAT TRIGGERS OR CHALLENGES SHOULD I REDUCE?

What made things worse or more difficult?

- _____
- _____
- _____
- _____
- _____

8. LESSONS LEARNED

What did I learn about myself or my condition this week?

- _____
- _____
- _____
- _____
- _____

9. ADJUSTMENTS FOR NEXT WEEK

What will I do differently?

1. _____
2. _____
3. _____
4. _____
5. _____

10. NEXT WEEK PLAN – MY FOCUS AREAS

HEALTH	MOVEMENT	MINDSET	CONNECTION	HABIT
What is my main health focus?	What is my movement goal?	What is my mental focus?	How will I stay connected?	What habit will I build or strengthen?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
Action step: _____	Action step: _____	Action step: _____	Action step: _____	Action step: _____

11. COMMITMENT STATEMENT

I commit to taking small, consistent steps to improve my well-being.

My priority for next week is: _____

I will show up for myself by: _____

12. MOTIVATION REMINDER

Why am I doing this?

_____

_____

_____

Small steps. Consistent actions. Better days ahead.

Progress > Perfection

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.