

How Do You Feel Today?

A Personal Progress Chart

We tend to forget health problems that bothered us when they are gone. Use this chart to take inventory of how you feel as you begin a change and note your progress in 30, 60 and 90 days. Rate each condition in terms of frequency and/or intensity on a scale of 1 to 5 (1 being the best, 5 being worst). **Your Name** _____

Today	Condition	30 Days	60 Days	90 Days
1	_____ Low energy/ Often feel tired	1 _____	_____	_____
2	_____ Overweight or underweight	2 _____	_____	_____
3	_____ Skin problems – dry, itchy, acne, etc.	3 _____	_____	_____
4	_____ Headaches or migraines	4 _____	_____	_____
5	_____ Aching joints or arthritis	5 _____	_____	_____
6	_____ Diabetes or low blood sugar levels	6 _____	_____	_____
7	_____ Back Ache, Joints	7 _____	_____	_____
8	_____ Subject to colds and/or infections	8 _____	_____	_____
9	_____ High or low blood pressure	9 _____	_____	_____
10	_____ Depression	10 _____	_____	_____
11	_____ Cold hands and/or feet	11 _____	_____	_____
12	_____ Difficulty handling stress	12 _____	_____	_____
13	_____ Poor concentration, memory lapses	13 _____	_____	_____
14	_____ Allergies	14 _____	_____	_____
15	_____ Difficulty falling asleep or waking up	15 _____	_____	_____
16	_____ Digestive problems, heartburn, ulcers, etc	16 _____	_____	_____
17	_____ Constipation	17 _____	_____	_____
18	_____ Mouth problems – gums, teeth, bad breath	18 _____	_____	_____
19	_____ Hair problems – thinning, graying, dull	19 _____	_____	_____
20	_____ Eye problems	20 _____	_____	_____
21	_____ Varicose veins	21 _____	_____	_____
22	_____ Hemorrhoids	22 _____	_____	_____
23	_____ Asthma, shortness of breath	23 _____	_____	_____
24	_____ Heart and or circulatory problem	24 _____	_____	_____
25	_____ Take aspirin or pain pills often	25 _____	_____	_____
26	_____ Addictions – smoking, coffee, alcohol, drugs	26 _____	_____	_____
27	_____ Hearing problems	27 _____	_____	_____
28	_____ Immune system problems	28 _____	_____	_____
29	_____ Cuts and/or bruises heal slowly	29 _____	_____	_____
30	_____ Water retention, bloating	30 _____	_____	_____
31	_____ Lack of strength, weakness	31 _____	_____	_____
32	_____ UTI, Incontinence	32 _____	_____	_____
33	_____ Menstrual cramps/ Moodiness/ PMS	33 _____	_____	_____
34	_____ Tremors	34 _____	_____	_____
35	_____ _____	35 _____	_____	_____
36	_____ _____	36 _____	_____	_____
37	_____ _____	37 _____	_____	_____
38	_____ _____	38 _____	_____	_____