Date: _____ / _____ Time: _____ pm/am

Last food: _____

_____

_____

_____

Last drinks: _____

Alcohol: Yes / No Caffeine: Low Normal High

Caffeine today: Low Normal High

Indoors / Outdoors Weather factors: _____

Loud noises? Yes / No Unusual smells: _____

Activities: _____

_____

_____

Exertion level: Low Normal High Hours sleep last night: _____

Stress level Low Normal High From: _____

Other notes: _____

_____

_____

_____