

Name:

Day:

Date:

Time	Activities & Steps	Perceived Exertion	Specific Muscle Weakness	Overall Fatigue	Pain Mood Breathing	Activities that produced Symptoms & Modifications
Up	Food?:  Sleep Quality?:					Activity:  Symptom:  How did you do the activity & how were you positioned?
<b>BREAK</b>						Symptom:  How did you do the activity & how were you positioned?  How could you modify?
Noon	Food?:					Activity:  Symptom:  How did you do the activity & how were you positioned?  How could you modify?
<b>BREAK</b>						Symptom:  How did you do the activity & how were you positioned?  How could you modify?
6 pm	Food?:					Activity:  Symptom:  How did you do the activity & how were you positioned?  How could you modify?
Bed						Activity:  Symptom:  How did you do the activity & how were you positioned?  How could you modify?
Total Steps:						

Perceived Exertion Scale

6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
Very, Very Light	Very Light	Very Light	Fairly Light	Somewhat Hard	Hard	Very Hard	Very, Very Hard							