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?:		Rate as mild-moderate-severe			
				—		Activity:
BREAK						Symptom:
						How did you do the activity & how were you positioned?
Noon	Food?:					How could you modify?
BREAK						Activity:
						Symptom:
6 pm	Food?:					How did you do the activity & how were you positioned?
						How could you modify?
Bed	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		Fairly Light			Somewhat Hard		Hard		Very Hard		Very, Very Hard	