



Month: _____ Year: _____ My weight: _____

List all medications you are currently taking (including non-prescription medications):

Week of: _____

(Starting on the Monday of that week)

At the end of each day, check all the circles that apply to you throughout the day.

I am...	MON	TUES	WED	THUR	FRI	SAT	SUN
• Sad	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
• Worried	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
• Overwhelmed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
• Having difficulty concentrating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
• Less interested in things I used to enjoy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
• Irritable	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
• Tense, anxious	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

I'm experiencing...	MON	TUES	WED	THUR	FRI	SAT	SUN
• Digestive issues, stomach pains	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
• Headaches	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
• Low energy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
• Fatigue	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
• Unexplained aches and pains	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Check the days where the following has occurred.

	MON	TUES	WED	THUR	FRI	SAT	SUN
Did you take your antidepressant medication today?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Were you physically active today?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Did you eat well today?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Menstrual cycle	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Alcohol consumed (number of drinks)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hours slept – day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hours slept – night	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Complete the following section at the end of the week (Sunday)

Have you found that your symptoms have interfered with your ability to take part in or carry out any of the following:

	YES	NO
Social activities	<input type="radio"/>	<input type="radio"/>
Family activities	<input type="radio"/>	<input type="radio"/>
Responsibilities in the home	<input type="radio"/>	<input type="radio"/>
Work activities	<input type="radio"/>	<input type="radio"/>

Positive events that have happened this week:

How these events made me feel:

Negative events that have happened this week:

How these events made me feel:

If you're having thoughts about death or suicide, here are some resources for immediate help:

- Call your healthcare provider
- Go to the emergency room
- Call 911

Call your healthcare provider: _____

Call a friend: _____

Make sure to bring your completed diaries with you to your doctor's appointment.