DATE:

SYMPTOMS:

What symptoms are you experiencing?

SYMPTOM INTENSITY:

How intense are your current symptoms?

Hardly Noticeable — Very Severe

OTHER MEDICATIONS:

List any medications you're taking, including supplements.

OTHER NOTES:

Make a note of anything else you want to record, including unrelated symptoms or illnesses, outside factors such as stress or diet, or your overall impression of the product(s).

PRODUCT:

STRAIN OR BLEND:

CONSUMPTION METHOD/DOSAGE:

TOP TERPENES:

TIMELINE:

Track your experience by recording what time you consumed and how the effects feel over the next few hours. Include any unexpected or unpleasant effects.

IMMEDIATE EFFECTS:

AFTER 1 HOUR:

AFTER 2+ HOURS:

How would you rate your overall experience?

Terrible — Indifferent — Amazing

OVERALL EFFECTS:

Check all that apply.

- [ ] Balanced
- [ ] Calming
- [ ] Cheerful
- [ ] Chill
- [ ] Creative
- [ ] Dreamy
- [ ] Energizing
- [ ] Euphoric
- [ ] Focused
- [ ] Grounding
- [ ] Mellow
- [ ] Motivating
- [ ] Peaceful
- [ ] Relaxing
- [ ] Soothing
- [ ] Sleepy
- [ ] Uplifting
- [ ] Other: