

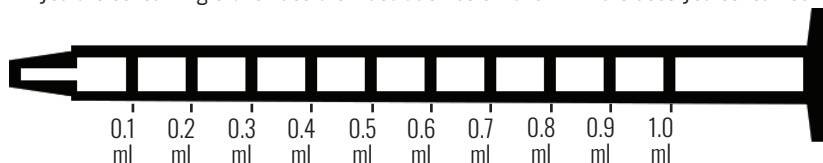
Date: \_\_\_\_\_

Licensed Producer: \_\_\_\_\_ Product/Strain: \_\_\_\_\_

Route of Administration: ☐ Inhalation ☐ Oral Oil ☐ Topical

Dose Consumed: \_\_\_\_\_

If you are consuming oral oil use the illustration below and fill in the dose you consumed.



Time Taken: \_\_\_\_\_ am pm Onset Time: \_\_\_\_\_ Duration of Effects: \_\_\_\_\_

### Positive Effects On Symptoms

- ☐ Pain Relief Muscle
  - ☐ Relaxation
  - ☐ Energizing
  - ☐ Motivating
  - ☐ Inflammation Reduct.
  - ☐ Improved Sleep
  - ☐ Other: \_\_\_\_\_
- ☐ Tremor Reduction
  - ☐ Seizure Reduction
  - ☐ Intestinal Ease
  - ☐ Appetite Stimulated
  - ☐ Mental Focus
  - ☐ Mood Lifted

### Negatives

- ☐ Anxiety
  - ☐ Dizziness
  - ☐ Drowsiness
  - ☐ Sleepiness
  - ☐ Nausea
  - ☐ Diarrhea
  - ☐ Other: \_\_\_\_\_
- ☐ Headache
  - ☐ Impaired
  - ☐ Memory Issues
  - ☐ Brain Fog
  - ☐ Fatigue
  - ☐ Dry Mouth

### How effective was your medication?

Mark an X or circle your overall feeling after taking your medication. Your optimal dose is the dose what gives you the most amount of symptom relief with the least amount of side effects.

-4	-3	-2	-1	0	1	2	3	4
Much Worse			No Change			Optimal		

### Notes

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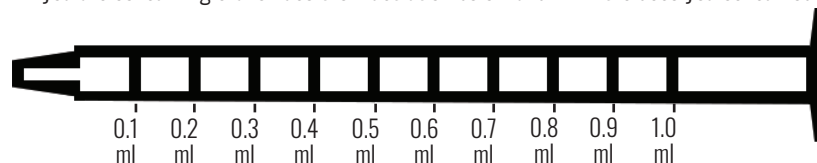
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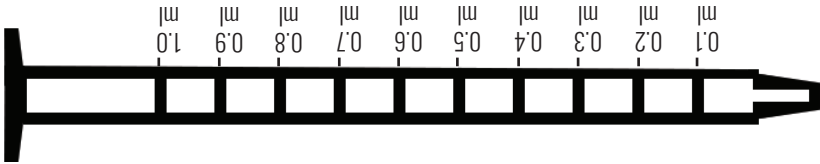
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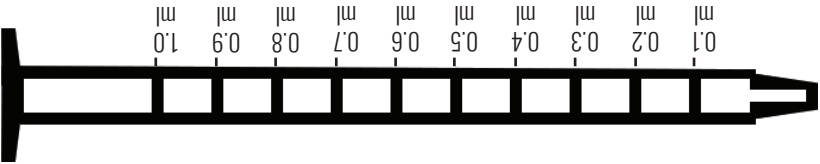
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