

# MY HEALTH NOW (BENCHMARK FOR YOUR DIARY)

START DATE:

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## MY OBJECTIVES

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

## PHYSICAL ASSESMENT

**PAIN** 5 4 3 2 1

HOW MUCH AND HOW OFTEN DOES IT HURT? MY NOTES:

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PAIN LOCATION

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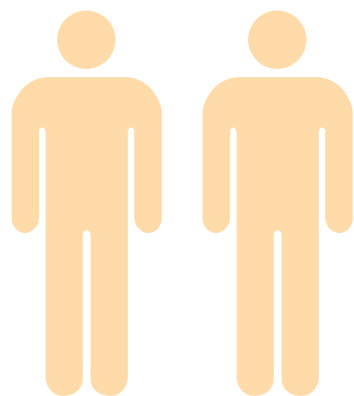
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FRONT

BACK

## PHYSICAL ASSESMENT CONTINUED...

**FATIGUE** 5 4 3 2 1

HOW TIRED DO I FEEL? WHEN?

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**ACTIVITY & INDEPENDENCE** 5 4 3 2 1

WHICH OF THESE ACTIVITIES ARE MOST DIFFICULT FOR ME?

### PERSONAL CARE:

WASHING	5	4	3	2	1
DRESSING	5	4	3	2	1
GOING TO THE TOILET	5	4	3	2	1
FEEDING	5	4	3	2	1

### EDUCATION / WORK:

STANDING	5	4	3	2	1
SITTING	5	4	3	2	1
TYPING	5	4	3	2	1
PARTICIPATION PART TIME OR FULL TIME	5	4	3	2	1

### LEISURE:

WALKING	5	4	3	2	1
SWIMMING	5	4	3	2	1
PLAYING SPORTS	5	4	3	2	1
GOING OUT	5	4	3	2	1

OTHER ACTIVITIES I HAVE DIFFICULTIES WITH:

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## EMOTIONAL ASSESMENT

### HOW DO I FEEL?



DO I FEEL OPTIMISTIC, HAPPY, DEPRESSED, AFRAID... OTHERS? WHY? MY NOTES:

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### RELATIONSHIPS AND SEXUALITY



HOW IS MY RELATIONSHIP GOING? IS MY SEXUAL LIFE SATISFYING? MY NOTES:

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### FAMILY AND FRIENDS



HOW MY CONDITION AFFECTS MY RELATIONSHIPS WITH FAMILY AND FRIENDS? MY NOTES:

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## MEDICATIONS

NAME OF THE MEDICATION	TYPE	WHEN PRESCRIBED?	DOSAGE	OUTCOMES (well- tolerated, not tolerated, effective, not effective, adverse reactions)
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### BASIC MEDICATIONS (e.g. NSAIDS)


### DISEASE MODIFYING MEDICATIONS (e.g. biologic modifications)


### NON-PRESCRIPTION MEDICATIONS


**MEDICATIONS CONTINUED...**

OTHERS (e.g. pain relief)


MAIN MEDICATIONS PRESCRIBED FOR OTHER CONDITIONS (e.g. high blood pressure)


**THERAPIES**

TYPE OF THERAPY	WHEN? FOR HOW LONG?	WHERE?	OUTCOMES
PHYSIOTHERAPY			
HYDROTHERAPY			
OCCUPATIONAL THERAPY			
OTHERS:			

**COMPLIMENTARY THERAPIES & SUPPLEMENTS**

TYPE OF THERAPY	WHEN? FOR HOW LONG?	WHERE?	OUTCOMES
VITAMINS			
HERBAL REMEDIES			
OSTEOPATHY/ CHIROPRACTIC			
MEDICATION			
OTHERS:			

LAST TESTS RESULTS				
TEST	TYPE	WHEN?	WHERE?	RESULTS
BLOOD				
MRI				
X-RAYS				
URINE				
OTHERS				

NEXT TESTS				
TEST	TYPE	WHEN?	WHERE?	RESULTS
BLOOD				
MRI				
X-RAYS				
URINE				
OTHERS				

## QUESTIONS TO ASK MY DOCTOR

A check list of suggested questions you might want to ask your doctor/specialist at a consultation, e.g.

- What is my condition and how will it develop?
- What sort of improvements can I expect from my treatment/s?
- How long will it take for this treatment to work?
- What kind of outcomes I can expect?
- What are the side effects of this treatment / these treatments?
- If there is no improvement in my condition when taking this medicine, is there an alternative treatment I could try?
- Are there any non-prescription medicines that could be helpful in managing my symptoms?
- What kind of activities/foods/drinks/other medicines should I avoid when taking this medicine?
- Would physiotherapy/other complimentary therapies suitable for me?
- Will the medicines I'm currently taking (list all of them) react with the medicines you have prescribed?
- Would you recommend exercise? If so, what type?

## QUESTIONS TO ASK ABOUT MY MEDICINES:

- What does this medicine do?
- How long will I need to use it?
- How and when should I take it?
- Should I avoid other medicines, drinks, foods or activities when taking this medicine?
- What possible are the possible risks and side effects and what should I do if they happen to me?

## HOW TO FILL IN YOUR CONSULTATION NOTES

### MY HEALTH

PAIN: Better / worse / change of location / other change etc

FATIGUE: Better / worse / after activity / time of day etc

ACTIVITIES: Personal care / shopping / work etc better / worse etc

ASSISTANCE NEEDED: Personal care / travel etc

SUMMARY OF CONSULTATION:

### MY MEDICATION

PRESCRIPTION MEDICINES: Medication / result / stopped taking etc

NON-PRESCRIPTION MEDICINES: Medication / dose / result / how used etc

SUPPLEMENTS: Vitamins / doses / herbal remedies / results

### MY ABILITY TO COPE

MUCH BETTER: General well being / ability to cope etc

FEELING LOW: Short term depression / long term depression needing help etc

### ANYTHING ELSE YOU COULD DO? / ANYTHING I COULD TRY?

Any other medications I could try? Other specialist or service you could refer me to for other problem? Self management course / devices /

Any sources of information / support? etc

### OTHER:

Other questions your doctor may be able to help with.

## NOTES FOR MY CONSULTATION

### MY HEALTH

PAIN:

FATIGUE:

ACTIVITIES:

ASSISTANCE NEEDED:

SUMMARY OF CONSULTATION:

### MY MEDICATION

PRESCRIPTION MEDICINES:

NON-PRESCRIPTION MEDICINES:

SUPPLEMENTS:

### MY ABILITY TO COPE

MUCH BETTER:

FEELING LOW:

### ANYTHING ELSE YOU COULD DO? / ANYTHING I COULD TRY?

### OTHER:

WEEK 1 / DATE:

PAIN

5 😊 4 ○ 3 ○ 2 ○ 1 ☹️

FATIGUE

5 🪓 4 ○ 3 ○ 2 ○ 1 🔥

ACTIVITY & INDEPENDENCE

5 🌞 4 ○ 3 ○ 2 ○ 1 🧑🏻

EMOTIONS

5 😊 4 ○ 3 ○ 2 ○ 1 ☹️

WHY:

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\_\_\_\_\_
\_\_\_\_\_

WEEK 2 / DATE:

PAIN

5 😊 4 ○ 3 ○ 2 ○ 1 ☹️

FATIGUE

5 🪓 4 ○ 3 ○ 2 ○ 1 🔥

ACTIVITY & INDEPENDENCE

5 🌞 4 ○ 3 ○ 2 ○ 1 🧑🏻

EMOTIONS

5 😊 4 ○ 3 ○ 2 ○ 1 ☹️

WHY:

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\_\_\_\_\_

WEEK 3 / DATE:

PAIN

5 😊 4 ○ 3 ○ 2 ○ 1 ☹️

FATIGUE

5 🪓 4 ○ 3 ○ 2 ○ 1 🔥

ACTIVITY & INDEPENDENCE

5 🌞 4 ○ 3 ○ 2 ○ 1 🧑🏻

EMOTIONS

5 😊 4 ○ 3 ○ 2 ○ 1 ☹️

WHY:

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NOTES:

RELATIONSHIPS & SEXUALITY

5 ❤️ 4 ○ 3 ○ 2 ○ 1 💔

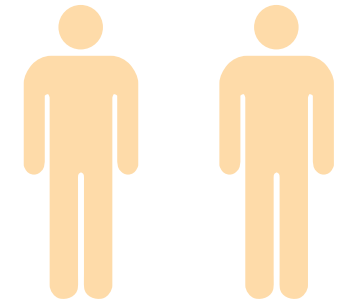
FAMILY & FRIENDS

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WHY:

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PAIN LOCATION



FRONT

BACK

REMINDER! WHAT IS HAPPENING IN YOUR LIFE?

Things i need to remember...

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\_\_\_\_\_

questions to ask my doctor...

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OVERALL PAIN SCALE

1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ○

Notes:

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