Name _____ Medication(s)_____

MEDICATION TRACKER

Week of _____

Things that affect focus & mood	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Write in Letters for Medications taken: Morning (M)/Lunch (L)/Evening(E)							
Amount of sleep at night							
Amount of sleep during the day							
Meals eaten (**G**ood **F**air **P**oor)	B L D	B L D	B L D	B L D	B L D	B L D	B L D
Snacks eaten							
Amount of exercise							
Amount of caffeine							
Stressors (tests, tryouts, friend drama, change, etc)							
Nicotine, CBD, marijuana or other mood altering substances							

Symptoms & Side Effects Rate 1 (least/poor) to 10 (most/good)	Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Focus/Attention							
Ability to transition tasks							
Memory							
Ability to prioritize tasks							
Ability to stay on task to completion							
Energy							
Feeling of overwhelm/anxiety/panic							
Feeling sad/depressed							
Feeling calm / happy							
Feeling too tired for time of day							
Ability to fall asleep							
Increased heart rate or chest pain							
Other:							