A MOMENT FOR YOUR WHOLE SELF

Daily Mood, Energy & Pain Check-In

Notice what is here today. No perfect words, scores, or completed boxes required.

Date **Time** Name / initials (optional)

01 How am I feeling?

Name a feeling or two. More than one can be true.

02 My energy and pain

Energy: low, mixed, steady, or your own words.

Pain: none, mild, moderate, severe, or other words.

03 Sleep and daily impact

How did I sleep? What feels easier or harder in daily life today?

04 What am I noticing?

What helped, felt difficult, or was happening around me? Patterns may take time.

05 What do I need today?

Rest, connection, practical help, a boundary, or something else?

One manageable next step

A question or change to share with my care team (optional)

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