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Patient Name: \_\_\_\_\_

= Increased    = Decreased    = No Change

Product (Brand) Name: \_\_\_\_\_ Concentration: \_\_\_\_\_ mg/ml    Ratio: \_\_\_\_\_    Start Date: \_\_\_\_\_

Product (Brand) Name: \_\_\_\_\_ Concentration: \_\_\_\_\_ mg/ml    Ratio: \_\_\_\_\_    Start Date: \_\_\_\_\_

Product (Brand) Name: \_\_\_\_\_ Concentration: \_\_\_\_\_ mg/ml    Ratio: \_\_\_\_\_    Start Date: \_\_\_\_\_

DATE	TIME OF ADMINISTRATION	DOSE	ACTIVITY*	PAIN LEVEL*	SLEEP HABITS*	APPETITE*	ANXIETY*	VOMITING +/-	DIARRHEA +/-	URINATION	SEIZURE #	OTHER OBSERVATIONS <small>*NOTE ANY CHANGE IN CANNABIS DOSING, PRODUCT OR CHANGES IN OTHER MEDICATIONS*</small>

\*Rate on a scale of 1-10 (1 being the worst, 10 being the best)