



DOSING JOURNAL

- **Everybody is different** – it will take some experimentation to find your ideal dose.
- **Take too small of a dose and you may not feel any effects at all, too high of a dose and you may experience undesirable results or a general worsening of symptoms.**
- **Less is more** – start low and slow with 1/2 recommended dose for 1 to 2 days, keeping track of your reactions and adjust dosage up or down accordingly.
- **Patience is essential** – while some people get results immediately, many report not seeing results for weeks.
- **NOTE:** Like grapefruit, CBD, CBG and CBN can interfere with your body's ability to process certain pharmaceutical drugs. Consult with your physician if you are on any prescription medications before using these products.

Product Name _____

Date _____

Time _____ Dosage (ml) _____

Time _____ Dosage (ml) _____

Time _____ Dosage (ml) _____

BEFORE DOSING

Describe general feelings prior to use.

EFFECTS

Write a symptom on each line. Indicate on charts how strong symptoms are before and after CBD dose.

SYMPTOM 1

| | |
|----------------------|----------------------|
| Before Dose | After Dose |
| <input type="text"/> | <input type="text"/> |
| Mild Intense | Mild Intense |

SYMPTOM 2

| | |
|----------------------|----------------------|
| Before Dose | After Dose |
| <input type="text"/> | <input type="text"/> |
| Mild Intense | Mild Intense |

SYMPTOM 3

| | |
|----------------------|----------------------|
| Before Dose | After Dose |
| <input type="text"/> | <input type="text"/> |
| Mild Intense | Mild Intense |

PERIODIC RESULTS

Record how your symptoms change hourly.

| | | | |
|------|---------------------------|----------------------|----------------------|
| 1 Hr | Worse | Same | Better |
| | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| | -4 -3 -2 -1 0 +1 +2 +3 +4 | | |

| | | | |
|-------|---------------------------|----------------------|----------------------|
| 2 Hrs | Worse | Same | Better |
| | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| | -4 -3 -2 -1 0 +1 +2 +3 +4 | | |

| | | | |
|-------|---------------------------|----------------------|----------------------|
| 3 Hrs | Worse | Same | Better |
| | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| | -4 -3 -2 -1 0 +1 +2 +3 +4 | | |

| | | | |
|-------|---------------------------|----------------------|----------------------|
| 4 Hrs | Worse | Same | Better |
| | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| | -4 -3 -2 -1 0 +1 +2 +3 +4 | | |

AFTER DOSING

In general, how do you feel after dosing?

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Date _____

Time _____ Dosage (ml) _____

Time _____ Dosage (ml) _____

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