

# Cannabis Dosing Log

## General Titration Suggestions:

- For a CBD-Dominant Strain, start at 5mg CBD per day, and increase dosage by 5mg every 2-4 days
- For a THC-Dominant Strain, start at 2.5mg THC at bedtime, and increase dosage by 1.25mg every 2-3 days

**IMPORTANT:** please follow your recommended dosage plan

**Symptom improvement:** Consider and record any improvements to pain, mood, sleep, nausea etc.

Example: include pain scores on scale of 1-10 before and after dosage.

**Side-Effects and Notes:** Note any side-effects experienced, such as depression, anxiety, impairment.

STRAIN:	<input type="checkbox"/> CBD-DOMINANT <input type="checkbox"/> THC-DOMINANT <input type="checkbox"/> 1:1 <input type="checkbox"/> OTHER
---------	---

DATE:	<input type="checkbox"/> AM <input type="checkbox"/> NOON <input type="checkbox"/> PM <input type="checkbox"/> BED	<input type="checkbox"/> OIL <input type="checkbox"/> VAPE <input type="checkbox"/> OTHER: _____	DOSE (G/ML):	OFFSET OF EFFECT _____ MIN/HR	DURATION OF EFFECT (HR)
SYMPTOM IMPROVEMENTS			SIDE-EFFECTS & NOTES		

DATE:	<input type="checkbox"/> AM <input type="checkbox"/> NOON <input type="checkbox"/> PM <input type="checkbox"/> BED	<input type="checkbox"/> OIL <input type="checkbox"/> VAPE <input type="checkbox"/> OTHER: _____	DOSE (G/ML):	OFFSET OF EFFECT _____ MIN/HR	DURATION OF EFFECT (HR)
SYMPTOM IMPROVEMENTS			SIDE-EFFECTS & NOTES		

DATE:	<input type="checkbox"/> AM <input type="checkbox"/> NOON <input type="checkbox"/> PM <input type="checkbox"/> BED	<input type="checkbox"/> OIL <input type="checkbox"/> VAPE <input type="checkbox"/> OTHER: _____	DOSE (G/ML):	OFFSET OF EFFECT _____ MIN/HR	DURATION OF EFFECT (HR)
SYMPTOM IMPROVEMENTS			SIDE-EFFECTS & NOTES		

DATE:	<input type="checkbox"/> AM <input type="checkbox"/> NOON <input type="checkbox"/> PM <input type="checkbox"/> BED	<input type="checkbox"/> OIL <input type="checkbox"/> VAPE <input type="checkbox"/> OTHER: _____	DOSE (G/ML):	OFFSET OF EFFECT _____ MIN/HR	DURATION OF EFFECT (HR)
SYMPTOM IMPROVEMENTS			SIDE-EFFECTS & NOTES		

DATE:	<input type="checkbox"/> AM <input type="checkbox"/> NOON <input type="checkbox"/> PM <input type="checkbox"/> BED	<input type="checkbox"/> OIL <input type="checkbox"/> VAPE <input type="checkbox"/> OTHER: _____	DOSE (G/ML):	OFFSET OF EFFECT _____ MIN/HR	DURATION OF EFFECT (HR)
SYMPTOM IMPROVEMENTS			SIDE-EFFECTS & NOTES		