



CIC SYMPTOM TRACKER

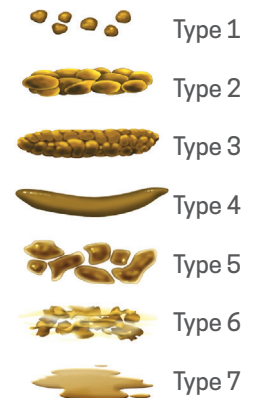
If you have Chronic Idiopathic Constipation (CIC), filling out this simple tracker may help when talking with your doctor and asking about the colon muscle connection. You can print as many copies as you need and mark the date where noted.

DAY	BOWEL MOVEMENT	CONSISTENCY	ACTIVITY AND STRESS LEVEL	FLUID AND FIBER INTAKE	TREATMENTS USED, IF ANY	SYMPTOMS EXPERIENCED
Mo	Yes <input type="checkbox"/> No <input type="checkbox"/>	Did it feel complete? Yes <input type="checkbox"/> No <input type="checkbox"/>	Rate your activity level Low <input type="checkbox"/> High <input type="checkbox"/>	Glasses of water <input type="checkbox"/>	Fiber <input type="checkbox"/>	Bloating <input type="checkbox"/>
	If yes, what time?	BSFS* (circle one) 1 2 3 4 5 6 7	Rate your stress level Low <input type="checkbox"/> High <input type="checkbox"/>	Grams of fiber <input type="checkbox"/>	OTC <input type="checkbox"/>	Straining <input type="checkbox"/>
Tu	Yes <input type="checkbox"/> No <input type="checkbox"/>	Did it feel complete? Yes <input type="checkbox"/> No <input type="checkbox"/>	Rate your activity level Low <input type="checkbox"/> High <input type="checkbox"/>	Glasses of water <input type="checkbox"/>	Fiber <input type="checkbox"/>	Bloating <input type="checkbox"/>
	If yes, what time?	BSFS* (circle one) 1 2 3 4 5 6 7	Rate your stress level Low <input type="checkbox"/> High <input type="checkbox"/>	Grams of fiber <input type="checkbox"/>	OTC <input type="checkbox"/>	Straining <input type="checkbox"/>
We	Yes <input type="checkbox"/> No <input type="checkbox"/>	Did it feel complete? Yes <input type="checkbox"/> No <input type="checkbox"/>	Rate your activity level Low <input type="checkbox"/> High <input type="checkbox"/>	Glasses of water <input type="checkbox"/>	Fiber <input type="checkbox"/>	Bloating <input type="checkbox"/>
	If yes, what time?	BSFS* (circle one) 1 2 3 4 5 6 7	Rate your stress level Low <input type="checkbox"/> High <input type="checkbox"/>	Grams of fiber <input type="checkbox"/>	OTC <input type="checkbox"/>	Straining <input type="checkbox"/>
Th	Yes <input type="checkbox"/> No <input type="checkbox"/>	Did it feel complete? Yes <input type="checkbox"/> No <input type="checkbox"/>	Rate your activity level Low <input type="checkbox"/> High <input type="checkbox"/>	Glasses of water <input type="checkbox"/>	Fiber <input type="checkbox"/>	Bloating <input type="checkbox"/>
	If yes, what time?	BSFS* (circle one) 1 2 3 4 5 6 7	Rate your stress level Low <input type="checkbox"/> High <input type="checkbox"/>	Grams of fiber <input type="checkbox"/>	OTC <input type="checkbox"/>	Straining <input type="checkbox"/>
Fr	Yes <input type="checkbox"/> No <input type="checkbox"/>	Did it feel complete? Yes <input type="checkbox"/> No <input type="checkbox"/>	Rate your activity level Low <input type="checkbox"/> High <input type="checkbox"/>	Glasses of water <input type="checkbox"/>	Fiber <input type="checkbox"/>	Bloating <input type="checkbox"/>
	If yes, what time?	BSFS* (circle one) 1 2 3 4 5 6 7	Rate your stress level Low <input type="checkbox"/> High <input type="checkbox"/>	Grams of fiber <input type="checkbox"/>	OTC <input type="checkbox"/>	Straining <input type="checkbox"/>
Sa	Yes <input type="checkbox"/> No <input type="checkbox"/>	Did it feel complete? Yes <input type="checkbox"/> No <input type="checkbox"/>	Rate your activity level Low <input type="checkbox"/> High <input type="checkbox"/>	Glasses of water <input type="checkbox"/>	Fiber <input type="checkbox"/>	Bloating <input type="checkbox"/>
	If yes, what time?	BSFS* (circle one) 1 2 3 4 5 6 7	Rate your stress level Low <input type="checkbox"/> High <input type="checkbox"/>	Grams of fiber <input type="checkbox"/>	OTC <input type="checkbox"/>	Straining <input type="checkbox"/>
Su	Yes <input type="checkbox"/> No <input type="checkbox"/>	Did it feel complete? Yes <input type="checkbox"/> No <input type="checkbox"/>	Rate your activity level Low <input type="checkbox"/> High <input type="checkbox"/>	Glasses of water <input type="checkbox"/>	Fiber <input type="checkbox"/>	Bloating <input type="checkbox"/>
	If yes, what time?	BSFS* (circle one) 1 2 3 4 5 6 7	Rate your stress level Low <input type="checkbox"/> High <input type="checkbox"/>	Grams of fiber <input type="checkbox"/>	OTC <input type="checkbox"/>	Straining <input type="checkbox"/>

STARTING DATE (DD/MM):

Bristol Stool Form Scale (BSFS)*

The BSFS is a useful tool for evaluating bowel movements



Adapted from Lacy BE, Mearin F, Chang L, et al. Gastroenterology. 2016; 150:1393-1407.

*BSFS refers to the Bristol Stool Form Scale, where 1 is hard, pellet-like stool (hard to pass) and 7 is entirely liquid (no solids). A smooth, soft stool is ~4

This information is not intended to diagnose medical conditions or take the place of talking to a qualified healthcare provider about medical conditions or treatment options.

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