BUILT FROM SCRATCH

Our PBC itch tracker helps you better understand your condition and have more insightful conversations with your care team.

Track pruritus for two weeks. Notice possible patterns, reflect on your sleep with weekly check-ins, and bring a clear summary to your next care conversation.

Start date _____ **End date** _____

Preferred name _____ **Diagnosis year** _____

Care team / clinic _____ **Next appointment** _____

Your paper. Your story.

This workbook stays with you unless you choose to share it. Store it somewhere private and bring it to appointments when helpful.

A free educational tool from Community Liver Alliance

This app and workbook are not medical devices and do not provide medical advice or diagnosis. Contact your care team with health questions. In an emergency, call 911.

How to use this tracker

1. Use one panel each day. Circle a number or check every item that applies.
2. Circle a daily sleep impact rating from 0–4. Complete the weekly sleep check-in after Day 7 and again after Day 14.
3. After Day 14, complete the review and prepare for your care conversation.
4. Skip anything you do not know or do not want to answer.

Your quick scales

Itch 0–10: 0 = no itch; 10 = worst imaginable.

Mood 0–4: 0 fine · 1 okay · 2 down · 3 very down · 4 a tough day.

Stress 0–4: 0 none · 1 a little · 2 moderate · 3 high · 4 overwhelmed.

Sleep 0–4: 0 no impact · 1 a little · 2 moderate · 3 high · 4 greatest impact.

Weekly sleep: Answer for the preceding seven days using the 1–10 difficulty scale shown.

About me during this tracking period

My usual itch level (0–10)

My preferred daily check-in time

Important health changes

What I most want my care team to understand

My treatments & therapies

Include prescriptions, over-the-counter products, topical products, supplements, biologics, and other therapies you want to track.

Name	Type / class	Dose & schedule	Started	Ended

Treatment notes before tracking begins

What seems to help, what is difficult, or questions to revisit

Allergies, sensitivities, or other notes for my care team

Privacy reminder: Avoid putting names, addresses, phone numbers, email addresses, or other identifying details in free-text notes.

Name: _____ Tracking period: _____

DAY 1 Date: _____

ITCH Circle: 0 1 2 3 4 5 6 7 8 9 10

Where?
☐ Scalp ☐ Face ☐ Arms ☐ Hands / palms ☐ Chest ☐ Back ☐ Belly ☐ Legs ☐ Feet / soles
☐ All over ☐ **Other Areas:** _____

When?
☐ Morning ☐ Afternoon ☐ Evening ☐ Overnight
Skin damage? ☐ Yes ☐ No

Mood 0 1 2 3 4 **Stress** 0 1 2 3 4 **Daily Sleep Impact** 0 1 2 3 4 **Treatments taken** ☐ All ☐ Some ☐ No ☐ N/A

Life impact
☐ Work ☐ Family life ☐ Relationships ☐ Physical activity ☐ Concentration

Possible triggers
☐ Heat ☐ Stress ☐ Tight clothing ☐ Evening hours ☐ Certain foods
☐ New medication ☐ Menstrual cycle ☐ Other

What helped?
☐ Cool compress ☐ Moisturizer ☐ Medication ☐ Distraction ☐ Nothing helped ☐ Other

Side effects
☐ Nausea ☐ Fatigue ☐ Headache ☐ GI upset ☐ Injection site
☐ Dizziness ☐ Rash ☐ Other

Treatment(s) that helped: _____

Notes (avoid names/contact information):

_____

DAY 2 Date: _____

ITCH Circle: 0 1 2 3 4 5 6 7 8 9 10

Where?
☐ Scalp ☐ Face ☐ Arms ☐ Hands / palms ☐ Chest ☐ Back ☐ Belly ☐ Legs ☐ Feet / soles
☐ All over ☐ **Other Areas:** _____

When?
☐ Morning ☐ Afternoon ☐ Evening ☐ Overnight
Skin damage? ☐ Yes ☐ No

Mood 0 1 2 3 4 **Stress** 0 1 2 3 4 **Daily Sleep Impact** 0 1 2 3 4 **Treatments taken** ☐ All ☐ Some ☐ No ☐ N/A

Life impact
☐ Work ☐ Family life ☐ Relationships ☐ Physical activity ☐ Concentration

Possible triggers
☐ Heat ☐ Stress ☐ Tight clothing ☐ Evening hours ☐ Certain foods
☐ New medication ☐ Menstrual cycle ☐ Other

What helped?
☐ Cool compress ☐ Moisturizer ☐ Medication ☐ Distraction ☐ Nothing helped ☐ Other

Side effects
☐ Nausea ☐ Fatigue ☐ Headache ☐ GI upset ☐ Injection site
☐ Dizziness ☐ Rash ☐ Other

Treatment(s) that helped: _____

Notes (avoid names/contact information):

_____

DAY 3 Date: _____

ITCH Circle: 0 1 2 3 4 5 6 7 8 9 10

Where?
☐ Scalp ☐ Face ☐ Arms ☐ Hands / palms ☐ Chest ☐ Back ☐ Belly ☐ Legs ☐ Feet / soles
☐ All over ☐ **Other Areas:** _____

When?
☐ Morning ☐ Afternoon ☐ Evening ☐ Overnight
Skin damage? ☐ Yes ☐ No

Mood 0 1 2 3 4 **Stress** 0 1 2 3 4 **Daily Sleep Impact** 0 1 2 3 4 **Treatments taken** ☐ All ☐ Some ☐ No ☐ N/A

Life impact
☐ Work ☐ Family life ☐ Relationships ☐ Physical activity ☐ Concentration

Possible triggers
☐ Heat ☐ Stress ☐ Tight clothing ☐ Evening hours ☐ Certain foods
☐ New medication ☐ Menstrual cycle ☐ Other

What helped?
☐ Cool compress ☐ Moisturizer ☐ Medication ☐ Distraction ☐ Nothing helped ☐ Other

Side effects
☐ Nausea ☐ Fatigue ☐ Headache ☐ GI upset ☐ Injection site
☐ Dizziness ☐ Rash ☐ Other

Treatment(s) that helped: _____

Notes (avoid names/contact information):

_____

Scale reminder: Itch 0 none → 10 worst imaginable · Mood / Stress / Sleep 0 lowest → 4 greatest impact · Complete the sleep check-in after each week

DAY 4 Date: _____

ITCH Circle: 0 1 2 3 4 5 6 7 8 9 10

Where?
☐ Scalp ☐ Face ☐ Arms ☐ Hands / palms ☐ Chest ☐ Back ☐ Belly ☐ Legs ☐ Feet / soles
☐ All over ☐ **Other Areas:** _____

When?
☐ Morning ☐ Afternoon ☐ Evening ☐ Overnight
Skin damage? ☐ Yes ☐ No

Mood 0 1 2 3 4 **Stress** 0 1 2 3 4 **Daily Sleep Impact** 0 1 2 3 4 **Treatments taken** ☐ All ☐ Some ☐ No ☐ N/A

Life impact
☐ Work ☐ Family life ☐ Relationships ☐ Physical activity ☐ Concentration

Possible triggers
☐ Heat ☐ Stress ☐ Tight clothing ☐ Evening hours ☐ Certain foods
☐ New medication ☐ Menstrual cycle ☐ Other

What helped?
☐ Cool compress ☐ Moisturizer ☐ Medication ☐ Distraction ☐ Nothing helped ☐ Other

Side effects
☐ Nausea ☐ Fatigue ☐ Headache ☐ GI upset ☐ Injection site
☐ Dizziness ☐ Rash ☐ Other

Treatment(s) that helped: _____

Notes (avoid names/contact information):

_____

DAY 5 Date: _____

ITCH Circle: 0 1 2 3 4 5 6 7 8 9 10

Where?
☐ Scalp ☐ Face ☐ Arms ☐ Hands / palms ☐ Chest ☐ Back ☐ Belly ☐ Legs ☐ Feet / soles
☐ All over ☐ **Other Areas:** _____

When?
☐ Morning ☐ Afternoon ☐ Evening ☐ Overnight
Skin damage? ☐ Yes ☐ No

Mood 0 1 2 3 4 **Stress** 0 1 2 3 4 **Daily Sleep Impact** 0 1 2 3 4 **Treatments taken** ☐ All ☐ Some ☐ No ☐ N/A

Life impact
☐ Work ☐ Family life ☐ Relationships ☐ Physical activity ☐ Concentration

Possible triggers
☐ Heat ☐ Stress ☐ Tight clothing ☐ Evening hours ☐ Certain foods
☐ New medication ☐ Menstrual cycle ☐ Other

What helped?
☐ Cool compress ☐ Moisturizer ☐ Medication ☐ Distraction ☐ Nothing helped ☐ Other

Side effects
☐ Nausea ☐ Fatigue ☐ Headache ☐ GI upset ☐ Injection site
☐ Dizziness ☐ Rash ☐ Other

Treatment(s) that helped: _____

Notes (avoid names/contact information):

_____

DAY 6 Date: _____

ITCH Circle: 0 1 2 3 4 5 6 7 8 9 10

Where?
☐ Scalp ☐ Face ☐ Arms ☐ Hands / palms ☐ Chest ☐ Back ☐ Belly ☐ Legs ☐ Feet / soles
☐ All over ☐ **Other Areas:** _____

When?
☐ Morning ☐ Afternoon ☐ Evening ☐ Overnight
Skin damage? ☐ Yes ☐ No

Mood 0 1 2 3 4 **Stress** 0 1 2 3 4 **Daily Sleep Impact** 0 1 2 3 4 **Treatments taken** ☐ All ☐ Some ☐ No ☐ N/A

Life impact
☐ Work ☐ Family life ☐ Relationships ☐ Physical activity ☐ Concentration

Possible triggers
☐ Heat ☐ Stress ☐ Tight clothing ☐ Evening hours ☐ Certain foods
☐ New medication ☐ Menstrual cycle ☐ Other

What helped?
☐ Cool compress ☐ Moisturizer ☐ Medication ☐ Distraction ☐ Nothing helped ☐ Other

Side effects
☐ Nausea ☐ Fatigue ☐ Headache ☐ GI upset ☐ Injection site
☐ Dizziness ☐ Rash ☐ Other

Treatment(s) that helped: _____

Notes (avoid names/contact information):

_____

Scale reminder: Itch 0 none → 10 worst imaginable · Mood / Stress / Sleep 0 lowest → 4 greatest impact · Complete the sleep check-in after each week

DAY 7 Date: _____

ITCH Circle: 0 1 2 3 4 5 6 7 8 9 10

Where?
☐ Scalp ☐ Face ☐ Arms ☐ Hands / palms ☐ Chest ☐ Back ☐ Belly ☐ Legs ☐ Feet / soles
☐ All over ☐ **Other Areas:** _____

When?
☐ Morning ☐ Afternoon ☐ Evening ☐ Overnight
Skin damage? ☐ Yes ☐ No

Mood 0 1 2 3 4 **Stress** 0 1 2 3 4 **Daily Sleep Impact** 0 1 2 3 4 **Treatments taken** ☐ All ☐ Some ☐ No ☐ N/A

Life impact
☐ Work ☐ Family life ☐ Relationships ☐ Physical activity ☐ Concentration

Possible triggers
☐ Heat ☐ Stress ☐ Tight clothing ☐ Evening hours ☐ Certain foods
☐ New medication ☐ Menstrual cycle ☐ Other

What helped?
☐ Cool compress ☐ Moisturizer ☐ Medication ☐ Distraction ☐ Nothing helped ☐ Other

Side effects
☐ Nausea ☐ Fatigue ☐ Headache ☐ GI upset ☐ Injection site
☐ Dizziness ☐ Rash ☐ Other

Treatment(s) that helped: _____

Notes (avoid names/contact information):

End-of-week notes

What stood out this week

What I want to remember before completing the sleep check-in

Scale reminder: Itch 0 none → 10 worst imaginable · Mood / Stress / Sleep 0 lowest → 4 greatest impact · Complete the sleep check-in after each week

My week of sleep

Personal tracking · Week 1 · Complete after Day 7

Week beginning: _____ **Date completed:** _____

Think about the seven days you just tracked. Circle one number in each row. Rate the amount of difficulty or interference, not the number of nights. Leave a row blank if it does not apply.

1 = least difficulty or interference (best). 10 = greatest difficulty or interference (worst). Numbers 2–9 show increasing difficulty.

How much did itch interfere with your planned bedtime?	1	2	3	4	5	6	7	8	9	10
How much did scratching interrupt your nighttime rest?	1	2	3	4	5	6	7	8	9	10
How difficult was it to keep a consistent bedtime and wake-up schedule?	1	2	3	4	5	6	7	8	9	10
How much did your sleeping environment (such as noise or temperature) get in the way of rest?	1	2	3	4	5	6	7	8	9	10
How much did sleep-related tiredness limit the activities you wanted to do during the day?	1	2	3	4	5	6	7	8	9	10
How much did managing sleep difficulties add to your overall daily burden?	1	2	3	4	5	6	7	8	9	10

Sleep notes

What stood out, and what would you like your care team to know?

Original personal tracking questions—not a validated screening tool. There is no clinical score, diagnostic cutoff, or treatment recommendation. Use your individual ratings and notes to describe your experience to your care team.

DAY 8 Date: _____

ITCH Circle: 0 1 2 3 4 5 6 7 8 9 10

Where?
☐ Scalp ☐ Face ☐ Arms ☐ Hands / palms ☐ Chest ☐ Back ☐ Belly ☐ Legs ☐ Feet / soles
☐ All over ☐ **Other Areas:** _____

When?
☐ Morning ☐ Afternoon ☐ Evening ☐ Overnight
Skin damage? ☐ Yes ☐ No

Mood 0 1 2 3 4 **Stress** 0 1 2 3 4 **Daily Sleep Impact** 0 1 2 3 4 **Treatments taken** ☐ All ☐ Some ☐ No ☐ N/A

Life impact
☐ Work ☐ Family life ☐ Relationships ☐ Physical activity ☐ Concentration

Possible triggers
☐ Heat ☐ Stress ☐ Tight clothing ☐ Evening hours ☐ Certain foods
☐ New medication ☐ Menstrual cycle ☐ Other

What helped?
☐ Cool compress ☐ Moisturizer ☐ Medication ☐ Distraction ☐ Nothing helped ☐ Other

Side effects
☐ Nausea ☐ Fatigue ☐ Headache ☐ GI upset ☐ Injection site
☐ Dizziness ☐ Rash ☐ Other

Treatment(s) that helped: _____

Notes (avoid names/contact information):

_____

DAY 9 Date: _____

ITCH Circle: 0 1 2 3 4 5 6 7 8 9 10

Where?
☐ Scalp ☐ Face ☐ Arms ☐ Hands / palms ☐ Chest ☐ Back ☐ Belly ☐ Legs ☐ Feet / soles
☐ All over ☐ **Other Areas:** _____

When?
☐ Morning ☐ Afternoon ☐ Evening ☐ Overnight
Skin damage? ☐ Yes ☐ No

Mood 0 1 2 3 4 **Stress** 0 1 2 3 4 **Daily Sleep Impact** 0 1 2 3 4 **Treatments taken** ☐ All ☐ Some ☐ No ☐ N/A

Life impact
☐ Work ☐ Family life ☐ Relationships ☐ Physical activity ☐ Concentration

Possible triggers
☐ Heat ☐ Stress ☐ Tight clothing ☐ Evening hours ☐ Certain foods
☐ New medication ☐ Menstrual cycle ☐ Other

What helped?
☐ Cool compress ☐ Moisturizer ☐ Medication ☐ Distraction ☐ Nothing helped ☐ Other

Side effects
☐ Nausea ☐ Fatigue ☐ Headache ☐ GI upset ☐ Injection site
☐ Dizziness ☐ Rash ☐ Other

Treatment(s) that helped: _____

Notes (avoid names/contact information):

_____

DAY 10 Date: _____

ITCH Circle: 0 1 2 3 4 5 6 7 8 9 10

Where?
☐ Scalp ☐ Face ☐ Arms ☐ Hands / palms ☐ Chest ☐ Back ☐ Belly ☐ Legs ☐ Feet / soles
☐ All over ☐ **Other Areas:** _____

When?
☐ Morning ☐ Afternoon ☐ Evening ☐ Overnight
Skin damage? ☐ Yes ☐ No

Mood 0 1 2 3 4 **Stress** 0 1 2 3 4 **Daily Sleep Impact** 0 1 2 3 4 **Treatments taken** ☐ All ☐ Some ☐ No ☐ N/A

Life impact
☐ Work ☐ Family life ☐ Relationships ☐ Physical activity ☐ Concentration

Possible triggers
☐ Heat ☐ Stress ☐ Tight clothing ☐ Evening hours ☐ Certain foods
☐ New medication ☐ Menstrual cycle ☐ Other

What helped?
☐ Cool compress ☐ Moisturizer ☐ Medication ☐ Distraction ☐ Nothing helped ☐ Other

Side effects
☐ Nausea ☐ Fatigue ☐ Headache ☐ GI upset ☐ Injection site
☐ Dizziness ☐ Rash ☐ Other

Treatment(s) that helped: _____

Notes (avoid names/contact information):

_____

Scale reminder: Itch 0 none → 10 worst imaginable · Mood / Stress / Sleep 0 lowest → 4 greatest impact · Complete the sleep check-in after each week

DAY 11 Date: _____

ITCH Circle: 0 1 2 3 4 5 6 7 8 9 10

Where?
☐ Scalp ☐ Face ☐ Arms ☐ Hands / palms ☐ Chest ☐ Back ☐ Belly ☐ Legs ☐ Feet / soles
☐ All over ☐ **Other Areas:** _____

When?
☐ Morning ☐ Afternoon ☐ Evening ☐ Overnight
Skin damage? ☐ Yes ☐ No

Mood 0 1 2 3 4 **Stress** 0 1 2 3 4 **Daily Sleep Impact** 0 1 2 3 4 **Treatments taken** ☐ All ☐ Some ☐ No ☐ N/A

Life impact
☐ Work ☐ Family life ☐ Relationships ☐ Physical activity ☐ Concentration

Possible triggers
☐ Heat ☐ Stress ☐ Tight clothing ☐ Evening hours ☐ Certain foods
☐ New medication ☐ Menstrual cycle ☐ Other

What helped?
☐ Cool compress ☐ Moisturizer ☐ Medication ☐ Distraction ☐ Nothing helped ☐ Other

Side effects
☐ Nausea ☐ Fatigue ☐ Headache ☐ GI upset ☐ Injection site
☐ Dizziness ☐ Rash ☐ Other

Treatment(s) that helped: _____

Notes (avoid names/contact information):

_____

DAY 12 Date: _____

ITCH Circle: 0 1 2 3 4 5 6 7 8 9 10

Where?
☐ Scalp ☐ Face ☐ Arms ☐ Hands / palms ☐ Chest ☐ Back ☐ Belly ☐ Legs ☐ Feet / soles
☐ All over ☐ **Other Areas:** _____

When?
☐ Morning ☐ Afternoon ☐ Evening ☐ Overnight
Skin damage? ☐ Yes ☐ No

Mood 0 1 2 3 4 **Stress** 0 1 2 3 4 **Daily Sleep Impact** 0 1 2 3 4 **Treatments taken** ☐ All ☐ Some ☐ No ☐ N/A

Life impact
☐ Work ☐ Family life ☐ Relationships ☐ Physical activity ☐ Concentration

Possible triggers
☐ Heat ☐ Stress ☐ Tight clothing ☐ Evening hours ☐ Certain foods
☐ New medication ☐ Menstrual cycle ☐ Other

What helped?
☐ Cool compress ☐ Moisturizer ☐ Medication ☐ Distraction ☐ Nothing helped ☐ Other

Side effects
☐ Nausea ☐ Fatigue ☐ Headache ☐ GI upset ☐ Injection site
☐ Dizziness ☐ Rash ☐ Other

Treatment(s) that helped: _____

Notes (avoid names/contact information):

_____

DAY 13 Date: _____

ITCH Circle: 0 1 2 3 4 5 6 7 8 9 10

Where?
☐ Scalp ☐ Face ☐ Arms ☐ Hands / palms ☐ Chest ☐ Back ☐ Belly ☐ Legs ☐ Feet / soles
☐ All over ☐ **Other Areas:** _____

When?
☐ Morning ☐ Afternoon ☐ Evening ☐ Overnight
Skin damage? ☐ Yes ☐ No

Mood 0 1 2 3 4 **Stress** 0 1 2 3 4 **Daily Sleep Impact** 0 1 2 3 4 **Treatments taken** ☐ All ☐ Some ☐ No ☐ N/A

Life impact
☐ Work ☐ Family life ☐ Relationships ☐ Physical activity ☐ Concentration

Possible triggers
☐ Heat ☐ Stress ☐ Tight clothing ☐ Evening hours ☐ Certain foods
☐ New medication ☐ Menstrual cycle ☐ Other

What helped?
☐ Cool compress ☐ Moisturizer ☐ Medication ☐ Distraction ☐ Nothing helped ☐ Other

Side effects
☐ Nausea ☐ Fatigue ☐ Headache ☐ GI upset ☐ Injection site
☐ Dizziness ☐ Rash ☐ Other

Treatment(s) that helped: _____

Notes (avoid names/contact information):

_____

DAY 14 Date: _____

ITCH Circle: 0 1 2 3 4 5 6 7 8 9 10

Where?
☐ Scalp ☐ Face ☐ Arms ☐ Hands / palms ☐ Chest ☐ Back ☐ Belly ☐ Legs ☐ Feet / soles
☐ All over ☐ **Other Areas:** _____

When?
☐ Morning ☐ Afternoon ☐ Evening ☐ Overnight
Skin damage? ☐ Yes ☐ No

Mood 0 1 2 3 4 **Stress** 0 1 2 3 4 **Daily Sleep Impact** 0 1 2 3 4 **Treatments taken** ☐ All ☐ Some ☐ No ☐ N/A

Life impact
☐ Work ☐ Family life ☐ Relationships ☐ Physical activity ☐ Concentration

Possible triggers
☐ Heat ☐ Stress ☐ Tight clothing ☐ Evening hours ☐ Certain foods
☐ New medication ☐ Menstrual cycle ☐ Other

What helped?
☐ Cool compress ☐ Moisturizer ☐ Medication ☐ Distraction ☐ Nothing helped ☐ Other

Side effects
☐ Nausea ☐ Fatigue ☐ Headache ☐ GI upset ☐ Injection site
☐ Dizziness ☐ Rash ☐ Other

Treatment(s) that helped: _____

Notes (avoid names/contact information):

End-of-week notes

What stood out this week

What I want to remember before completing the sleep check-in

Scale reminder: Itch 0 none → 10 worst imaginable · Mood / Stress / Sleep 0 lowest → 4 greatest impact · Complete the sleep check-in after each week

My week of sleep

Personal tracking · Week 2 · Complete after Day 14

Week beginning: _____ **Date completed:** _____

Think about the seven days you just tracked. Circle one number in each row. Rate the amount of difficulty or interference, not the number of nights. Leave a row blank if it does not apply.

1 = least difficulty or interference (best). 10 = greatest difficulty or interference (worst). Numbers 2–9 show increasing difficulty.

How much did itch interfere with your planned bedtime?	1	2	3	4	5	6	7	8	9	10
How much did scratching interrupt your nighttime rest?	1	2	3	4	5	6	7	8	9	10
How difficult was it to keep a consistent bedtime and wake-up schedule?	1	2	3	4	5	6	7	8	9	10
How much did your sleeping environment (such as noise or temperature) get in the way of rest?	1	2	3	4	5	6	7	8	9	10
How much did sleep-related tiredness limit the activities you wanted to do during the day?	1	2	3	4	5	6	7	8	9	10
How much did managing sleep difficulties add to your overall daily burden?	1	2	3	4	5	6	7	8	9	10

Sleep notes

What stood out, and what would you like your care team to know?

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LEVEL 2—Mood & Emotional Well-Being—Adult

PHQ-9—Patient Health Questionnaire

Name: **Age:** **Date:**

Complete this page after Day 14. Answer based on how you have felt during the two weeks you just tracked.

Instructions to patient: Over the past two weeks, how often have you been bothered by any of the following problems? Mark one box per row.

In the past TWO (2) WEEKS…	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	☐ 0	☐ 1	☐ 2	☐ 3
2. Feeling down, depressed, or hopeless	☐ 0	☐ 1	☐ 2	☐ 3
3. Trouble falling or staying asleep, or sleeping too much	☐ 0	☐ 1	☐ 2	☐ 3
4. Feeling tired or having little energy	☐ 0	☐ 1	☐ 2	☐ 3
5. Poor appetite or overeating	☐ 0	☐ 1	☐ 2	☐ 3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	☐ 0	☐ 1	☐ 2	☐ 3
7. Trouble concentrating on things, such as reading or watching television	☐ 0	☐ 1	☐ 2	☐ 3
8. Moving or speaking unusually slowly—or being so restless that you have been moving around more than usual	☐ 0	☐ 1	☐ 2	☐ 3
9. Thoughts that you would be better off dead or of hurting yourself in some way	☐ 0	☐ 1	☐ 2	☐ 3

Total score: _____ **/ 27**

Share this page with your care provider.

Notes — Include any details you'd like to share about your emotional well-being, including changes, concerns, or context from the past two weeks.

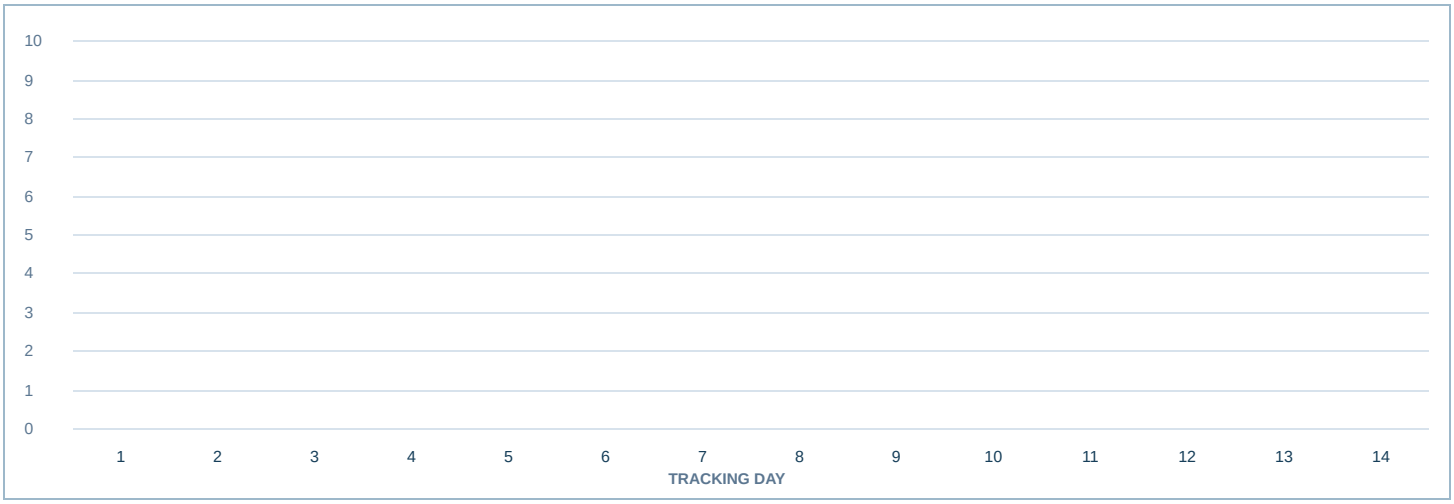
_____

_____

Important: This questionnaire is a screening tool, not a diagnosis. If you marked any response for item 9, contact a qualified health professional promptly. If you may act on thoughts of self-harm or are in immediate danger, call or text 988 in the U.S. or call 911.

See your itch over time

For each day, place a dot at the itch number you recorded. Connect the dots if helpful.



Days completed (out of 14)

Average itch (scores ÷ days completed)

Worst itch score

Sleep concern to discuss — Week 1 / Week 2

Days life was affected

Days with skin damage

Patterns I noticed

Itch was often worst at this time

Most affected body area(s), including Other Areas

Most common possible trigger(s)

What helped most often

Treatments during these two weeks

Days I took all treatments as planned

Treatment(s) that seemed to help

Side effect(s) I noticed most

Changes I want to discuss

How itch affected my life

Sleep, mood, stress, work, family, relationships, activity, or concentration

About these observations
Your totals and patterns are simple, rule-based statistics from what you wrote. They are not AI, a diagnosis, medical advice, or a substitute for your care team's judgment.

Make the conversation count.

Check the questions you want to ask. Write the answer or next step below each item.

- ☐ How often should I have blood tests or other monitoring?
- ☐ Do I need imaging or a liver biopsy?
- ☐ What symptoms should prompt me to contact my provider or go to the ED?
- ☐ What lifestyle modifications might help me manage my symptoms/avoid flares?
- ☐ Are there medications or supplements that I should avoid?
- ☐ How long will I need to take treatment?
- ☐ Should my family members be tested for PBC?
- ☐ Can PBC affect my fertility or pregnancy?
- ☐ Does PBC affect my life expectancy?
- ☐ Are there patient support groups or resources that you recommend?

My three highest-priority questions

1.

2.

3.

Bring your weekly sleep pages.
Discuss your individual ratings and notes with your care team. These ratings are for personal tracking, not clinical scoring.

Don’t just say it. Show it.

Use your two weeks of notes to focus the limited time you have with your care team.

Changes I noticed

Itch pattern / locations

Sleep / mood / stress

Daily life / work

Skin damage

Treatment questions

What helped

What did not help

Side effects

Adherence challenges

Notes from the appointment

Bring with you: ☐ This workbook ☐ Weekly sleep pages ☐ Medication list ☐ Questions ☐ Any photos you choose to share

Acknowledgment

This toolkit was made possible through an educational sponsorship from Alfasigma. The Community Liver Alliance gratefully acknowledges their support in empowering patients and caregivers affected by Primary Biliary Cholangitis (PBC).

ALFASIGMA