

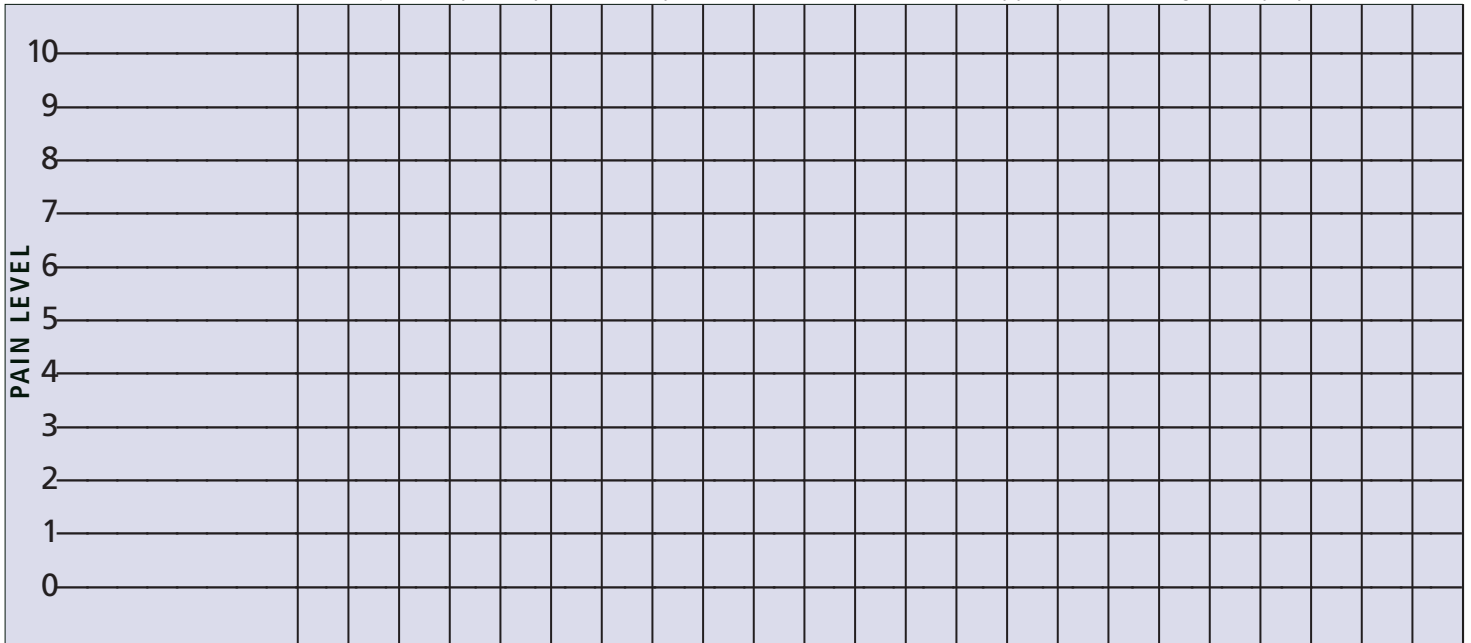
Name _____

Day _____

Date _____

1

DAILY PAIN CHART Connect the points on your Daily Pain Chart so your medical team can see when and why your pain level changed. Every day, start a new chart.



2

DAILY PAIN LOG
MEDICINES: NAME/DOSE
(insert # of pills taken)

	6am	7	8	9	10	11	12pm	1	2	3	4	5	6pm	7	8	9	10	11	12am	1	2	3	4	5
#1																								
#2																								
#3																								
#4																								
#5																								

NON-DRUG THERAPIES (other than prescription or other medicines)

ACTIVITIES/EXERCISE

COMMENTS AND MORE INFORMATION: Make notes for and about visits with your healthcare provider, side effects from treatments you may be experiencing, and any problems you are having coping with your pain. You may also want to write more about some of your answers on the previous page.

Name _____

Day _____

Date _____

3 DAILY PAIN SUMMARY

Did you have pain today? ___NO ___YES

Did you avoid or limit any of your activities or cancel plans today because of pain or changes in your pain?

___NO ___YES: **What activities?**

Did you take all your pain medicine today according to instructions? ___NO ___YES

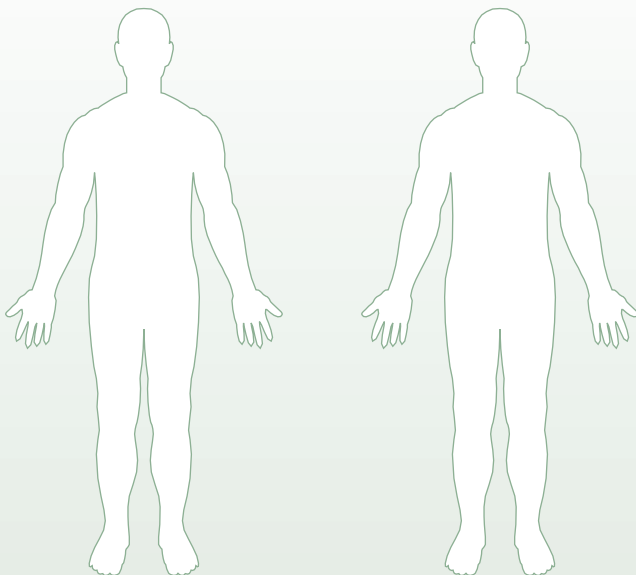
Even though you took your pain medicine for persistent pain on schedule, were there times during the day that you experienced unrelieved breakthrough pain? ___NO ___YES

How many times did this happen today?

1 2 3 4 5 6 7 8 9 10 more than 10

Did any specific activity start your breakthrough pain? ___NO ___YES: **What activities?**

Put an "X" on the body diagram to show each place you've had pain today.



What was your average level of pain today?

0 1 2 3 4 5 6 7 8 9 10

Other than prescription medicine, did you do anything else today to relieve the pain?

- ___ NO ___ YES (**Note any that you used.**)
 - ___ Non-prescription drugs (e.g., acetaminophen, ibuprofen)
 - ___ Herbal remedies
 - ___ Hot or cold packs
 - ___ Exercise
 - ___ Changing position (such as lying down or elevating your legs)
 - ___ Physical therapy
 - ___ Massage
 - ___ Acupuncture
 - ___ Rest
 - ___ Psychological counseling
 - ___ Talk to trusted friend, family, clergy
 - ___ Prayer, meditation, guided imagery
 - ___ Relaxation technique (hypnosis, biofeedback)
 - ___ Creative technique (art or music therapy)
 - ___ Other (e.g., specific chiropractic manipulation, osteopathic treatments):
-

Check any of these common side effects that you've noticed after taking your pain medicine.

- ___ Drowsiness, sleepiness
 - ___ Nausea, vomiting, upset stomach
 - ___ Constipation
 - ___ Lack of appetite
 - ___ Other (describe):
-

Did you skip any of your scheduled pain medicines today? ___NO ___YES: **Why?**

Did you call your doctor's office or clinic between visits because of pain? ___NO ___YES

Did you sleep through the night? ___NO ___YES
If not, how many times was your sleep disrupted?

How many hours did you sleep during the night?
_____ hours

Overall, are you satisfied with your pain management?
___YES ___NO (**Explain what makes you satisfied or not satisfied. Use Log section.**)

What pain level overall would you find acceptable?

0 1 2 3 4 5 6 7 8 9 10