2006 PAIN AWARENESS MONTH
September 1–30

# MY WEEKLY PAIN DIARY

**Patient Instructions:** Use this pain diary to record your pain, daily activities, and your medications. Fill in the information as best as possible and bring this with you to your next appointment. If you are experiencing severe pain, call your healthcare provider immediately.

PATIENT'S NAME ____________________ DOCTOR'S NAME ____________________

WEEK __________ MONTH __________ YEAR __________ PHONE ____________________

| PLEASE RECORD EACH DAY | TIME OF PAIN | ACTIVITIES CAUSING PAIN | WHERE IS PAIN? | LEVEL OF PAIN | 1ST MEDICATION | 2ND MEDICATION | LIST ADDITIONAL MEDICATIONS, HERBAL REMEDIES, SUPPLEMENTS, ETC. |
|---|---|---|---|---|---|---|---|
| | • Morning - AM<br>• Afternoon - PM<br>• Night - N<br>• All day - A | • Walking - W<br>• Sitting - S<br>• Standing - ST<br>• Bending - B<br>• Sleeping - SL<br>• List other | • Head<br>• Lower back<br>• Knees/Hips<br>• Hand/Fingers<br>• Legs<br>• Chest<br>• Pelvic Area<br>• List other | *(0-10)*<br>*0= no pain*<br>*5= moderate pain*<br>*10= worst pain* | • Name of med.<br>• Time taken? *(am/pm)*<br>• How often? *(once daily, every 4 hrs, before bed, etc.)*<br>• Level of relief *None - N* *Some - S* *Great - G*<br>• Time before feeling relief? | • Name of med.<br>• Time taken? *(am/pm)*<br>• How often? *(once daily, every 4 hrs, before bed, etc.)*<br>• Level of relief *None - N* *Some - S* *Great - G*<br>• Time before feeling relief? | |
| MON | | | | | | | |
| TUE | | | | | | | |
| WED | | | | | | | |
| THU | | | | | | | |
| FRI | | | | | | | |
| SAT | | | | | | | |
| SUN | | | | | | | |

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