Daily Pain Diary

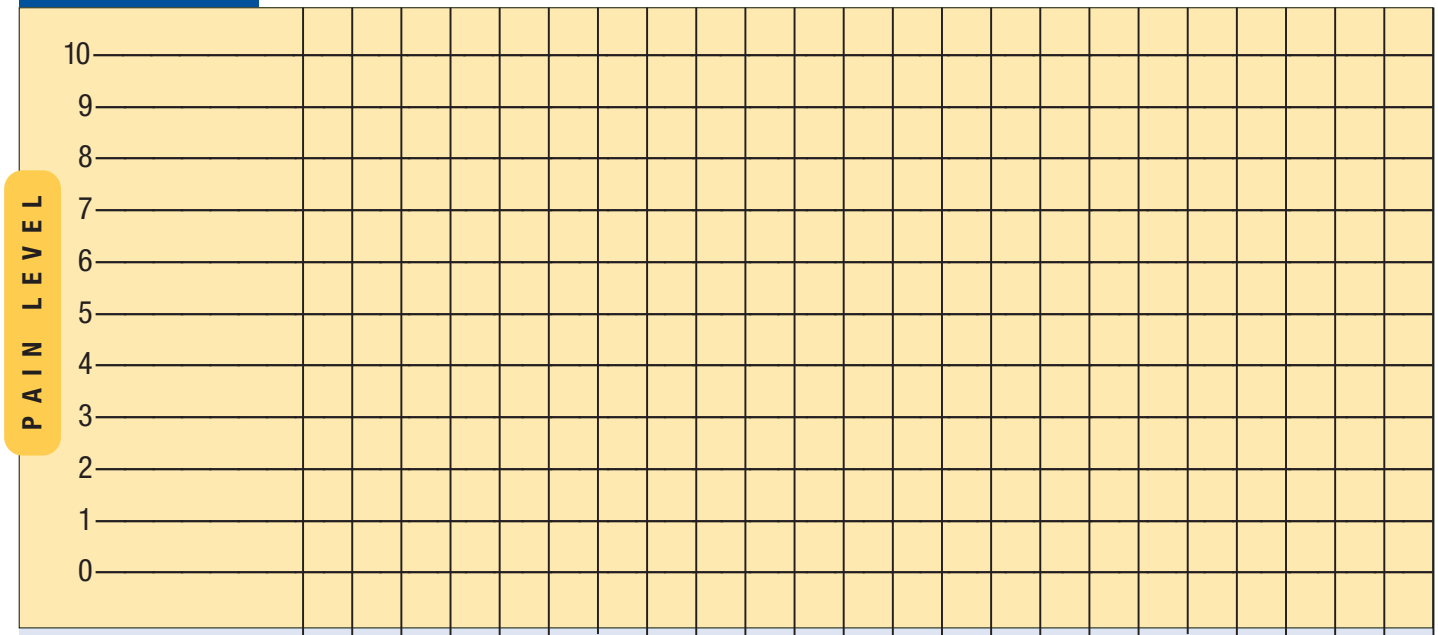
Name _____

Day _____

Date _____

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.



DAILY PAIN LOG

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

#1

#2

#3

#4

#5

NON-DRUG THERAPIES
(other than prescriptions 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.

Name _____

Day _____

Date _____

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?

0 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?**

What was your average level of pain today?

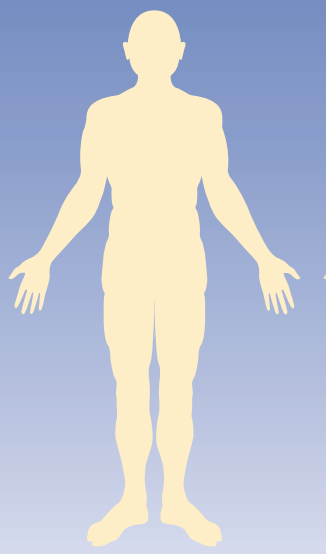
0 1 2 3 4 5 6 7 8 9 10

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

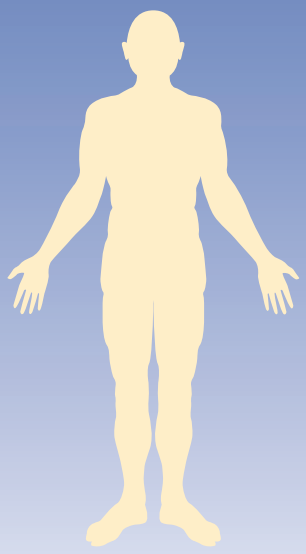
☐ NO ☐ YES **(Note any that you used.)**

_____ 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):

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



Front



Back

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?

☐ NO ☐ YES

(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