

Pain Diary for _____

List of Medicines for Pain and Side Effects

List all of the medicines your doctor gave you and all of the medicines you bought for yourself at the store.

- Name of medicines:
- Dose or amount:
- What it is for?
- What it looks like?
- When to take it
- Side effects

- Do they help?

Never
 Sometimes
 Always

- Have you stopped taking any medicines because they made you constipated, sleepy or sick, or for other reasons?
- Do you do anything to help make the pain go away other than taking medicine such as getting a massage, or meditating, etc.?

Pain Assessment

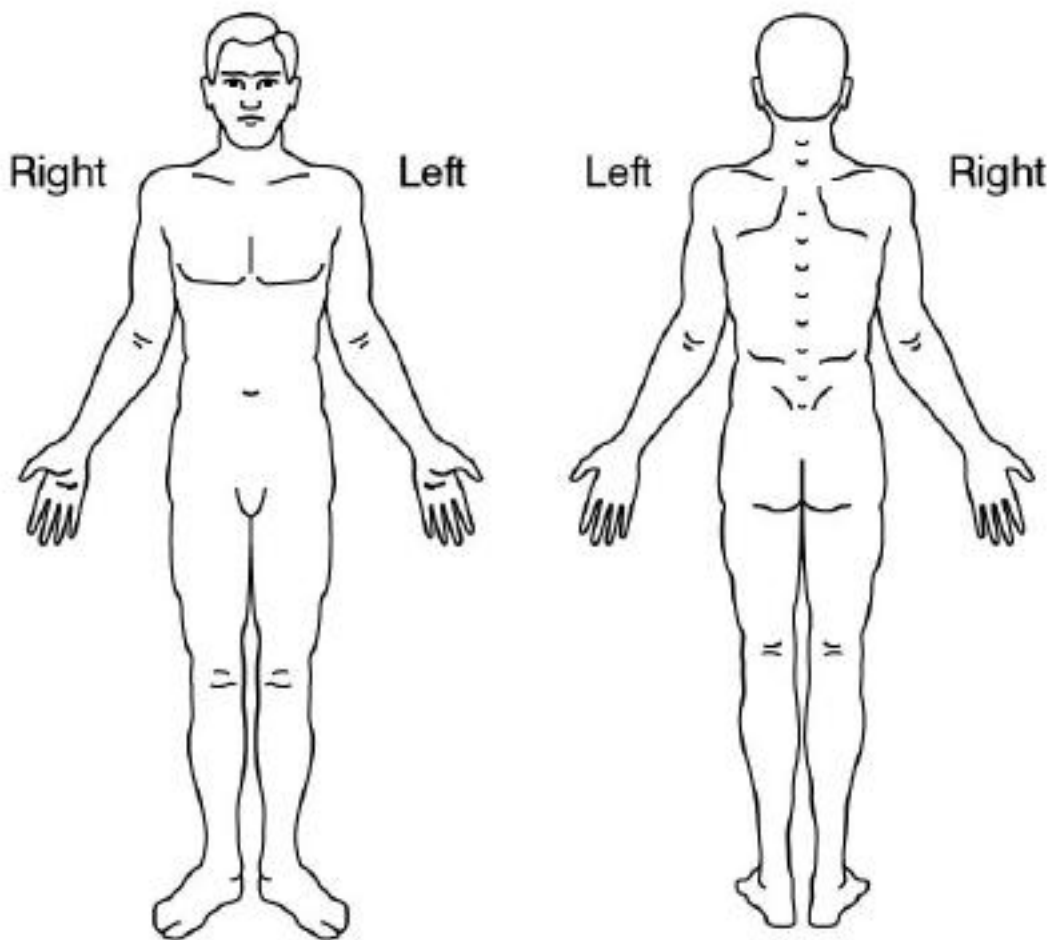
Answer the following questions to determine how the pain affects you. Use the diagram below to show where your pain is located.

DAY 1

DAY _____

DATE _____

- **Where does it hurt?** (Mark the body drawing to show where it hurts.)



- Is it always there, or does it come and go?
- Is this pain new?
- Does the pain move from one place to another?
- Where does it travel?

Pain Assessment (Cont.)

- How long does the pain last?
- What does the pain feel like? (burning, gnawing, sharp, etc.)
- Where did it start?
- How bad is it?
- Is there more than one kind of pain? (Describe each separately.)
- When do you have pain? (All the time? Only at night? Other times?)
- Does the pain interrupt your sleep?
- Do you wake up in the night or in the morning with pain?

Tools to Describe Pain

Pick one tool that makes sense to you. Use the tools below to show pain and how much relief you get from medicine and other things to manage pain.

0-10 Pain Scale

0 1 2 3 4 5 6 7 8 9 10
No Pain Worst Pain

Rate your pain or pain relief from 0 to 10.

Pain Distress Scale

None Annoying Uncomfortable Dreadful Horrible Agonizing

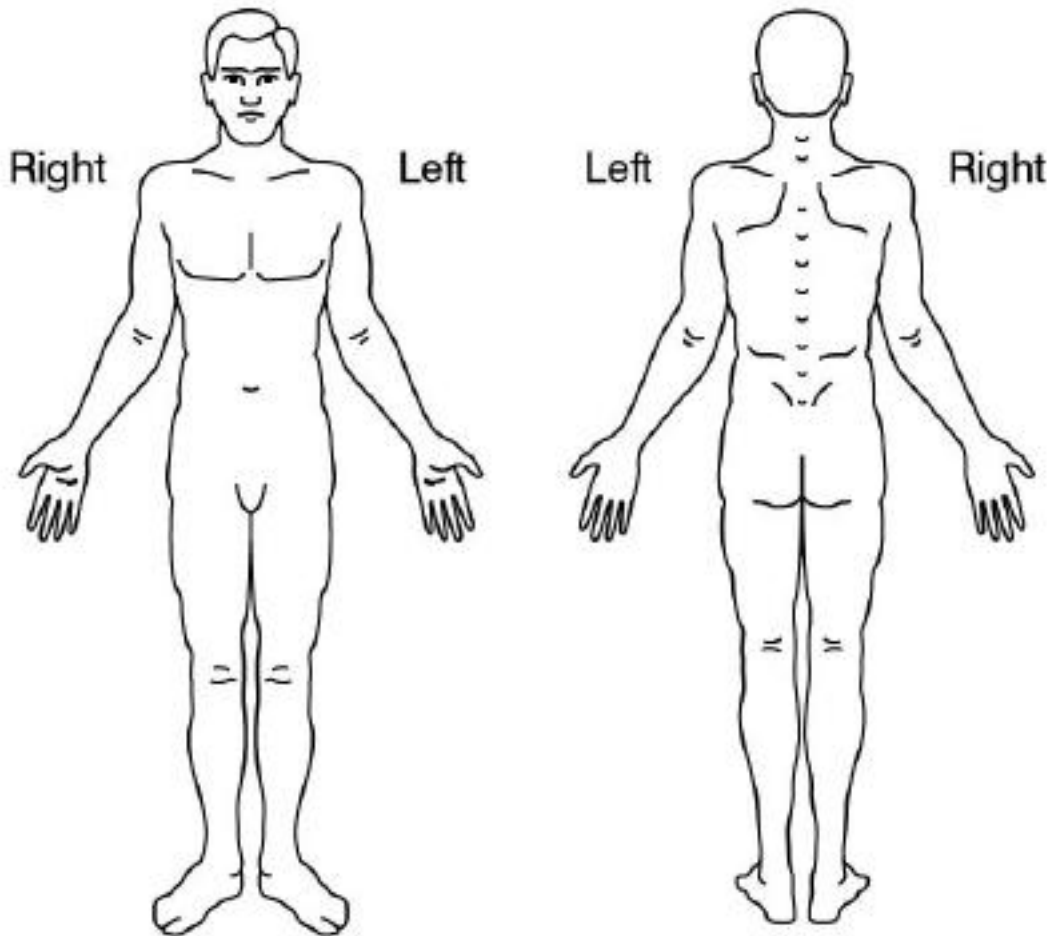
Mark the line to show how much pain you have.

DAY 2

DAY _____

DATE _____

- **Where does it hurt?** (Mark the body drawing to show where it hurts.)



- **Is it always there, or does it come and go?**
- **Is this pain new?**
- **Does the pain move from one place to another?**
- **Where does it travel?**
- **How long does the pain last?**
- **What does the pain feel like?** (burning, gnawing, sharp, etc.)

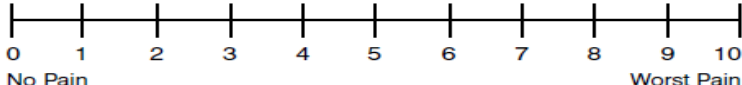
Pain Assessment (Cont.)

- **Where did it start?**
- **How bad is it?**
- **Is there more than one kind of pain?** (Describe each separately.)
- **When do you have pain?** (All the time? Only at night? Other times?)
- **Does the pain interrupt your sleep?**
- **Do you wake up in the night or in the morning with pain?**

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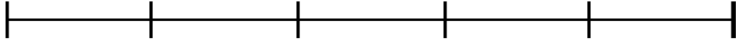


0 1 2 3 4 5 6 7 8 9 10
No Pain Worst Pain

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Pain Distress Scale

None Annoying Uncomfortable Dreadful Horrible Agonizing



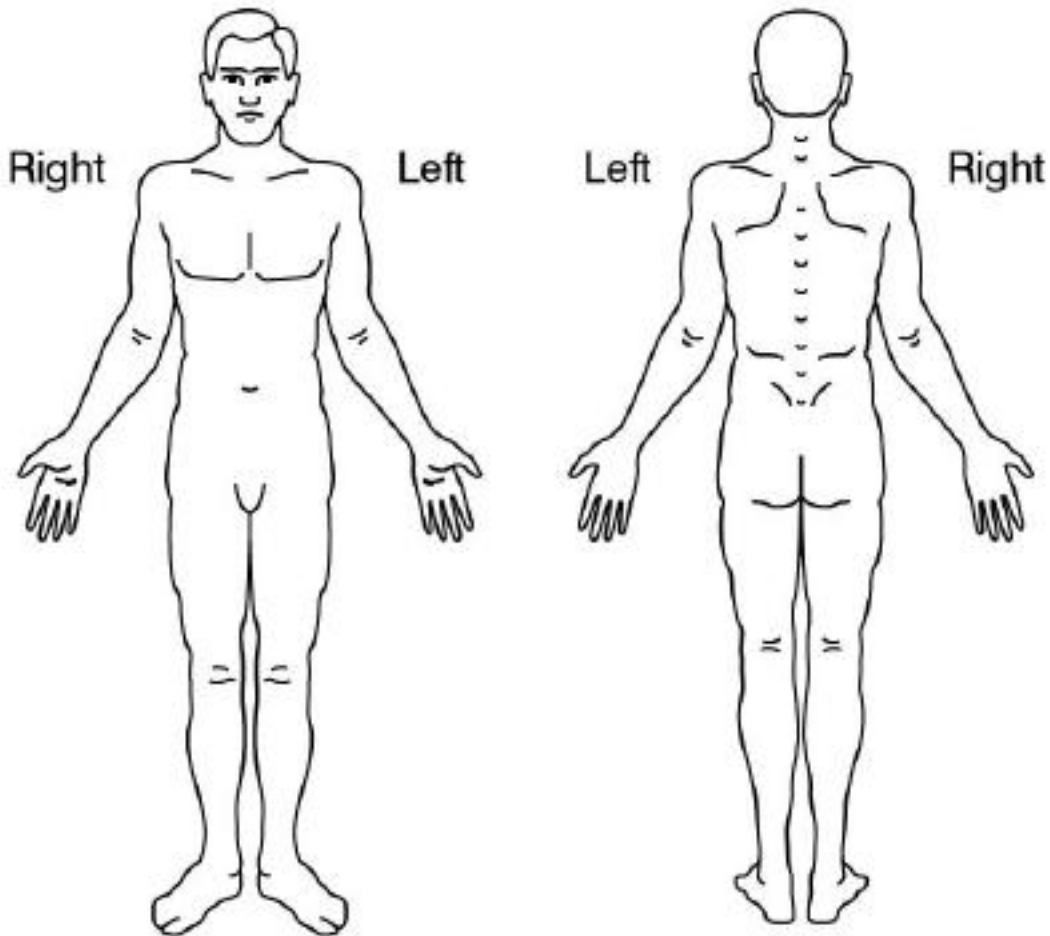
Mark the line to show how much pain you have.

DAY 3

DAY _____

DATE _____

- **Where does it hurt?** (Mark the body drawing to show where it hurts.)



- **Is it always there, or does it come and go?**
- **Is this pain new?**
- **Does the pain move from one place to another?**
- **Where does it travel?**
- **How long does the pain last?**
- **What does the pain feel like?** (burning, gnawing, sharp, etc.)

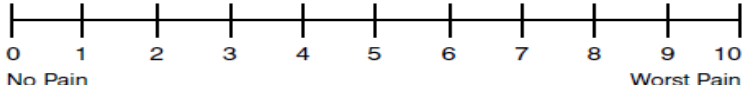
Pain Assessment (Cont.)

- **Where did it start?**
- **How bad is it?**
- **Is there more than one kind of pain?** (Describe each separately.)
- **When do you have pain?** (All the time? Only at night? Other times?)
- **Does the pain interrupt your sleep?**
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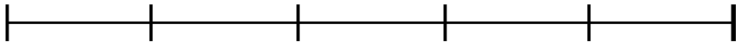


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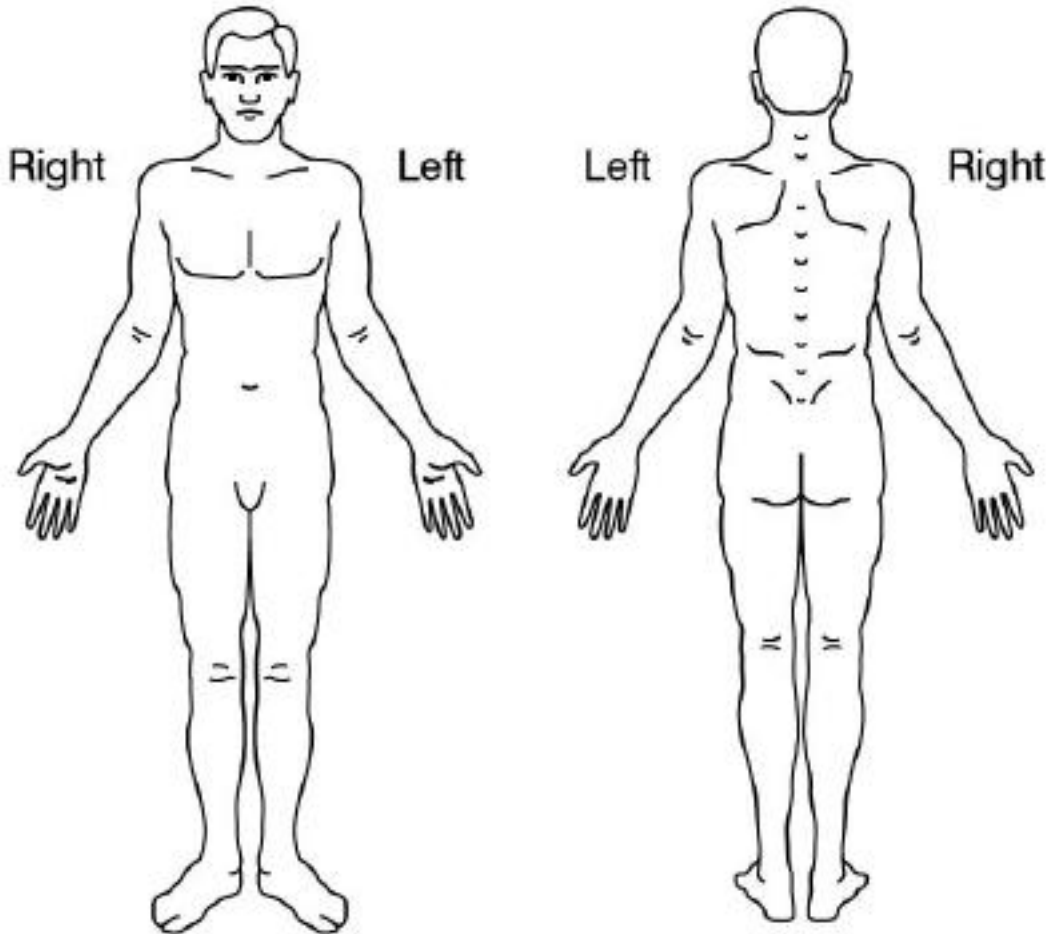
Mark the line to show how much pain you have.

DAY 4

DAY _____

DATE _____

- **Where does it hurt?** (Mark the body drawing to show where it hurts.)



- **Is it always there, or does it come and go?**
- **Is this pain new?**
- **Does the pain move from one place to another?**
- **Where does it travel?**
- **How long does the pain last?**
- **What does the pain feel like?** (burning, gnawing, sharp, etc.)

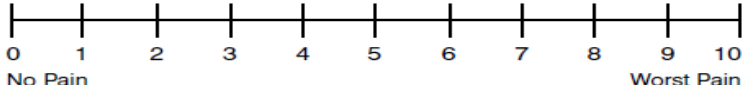
Pain Assessment (Cont.)

- **Where did it start?**
- **How bad is it?**
- **Is there more than one kind of pain?** (Describe each separately.)
- **When do you have pain?** (All the time? Only at night? Other times?)
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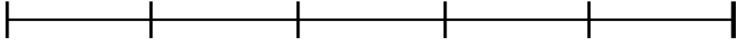


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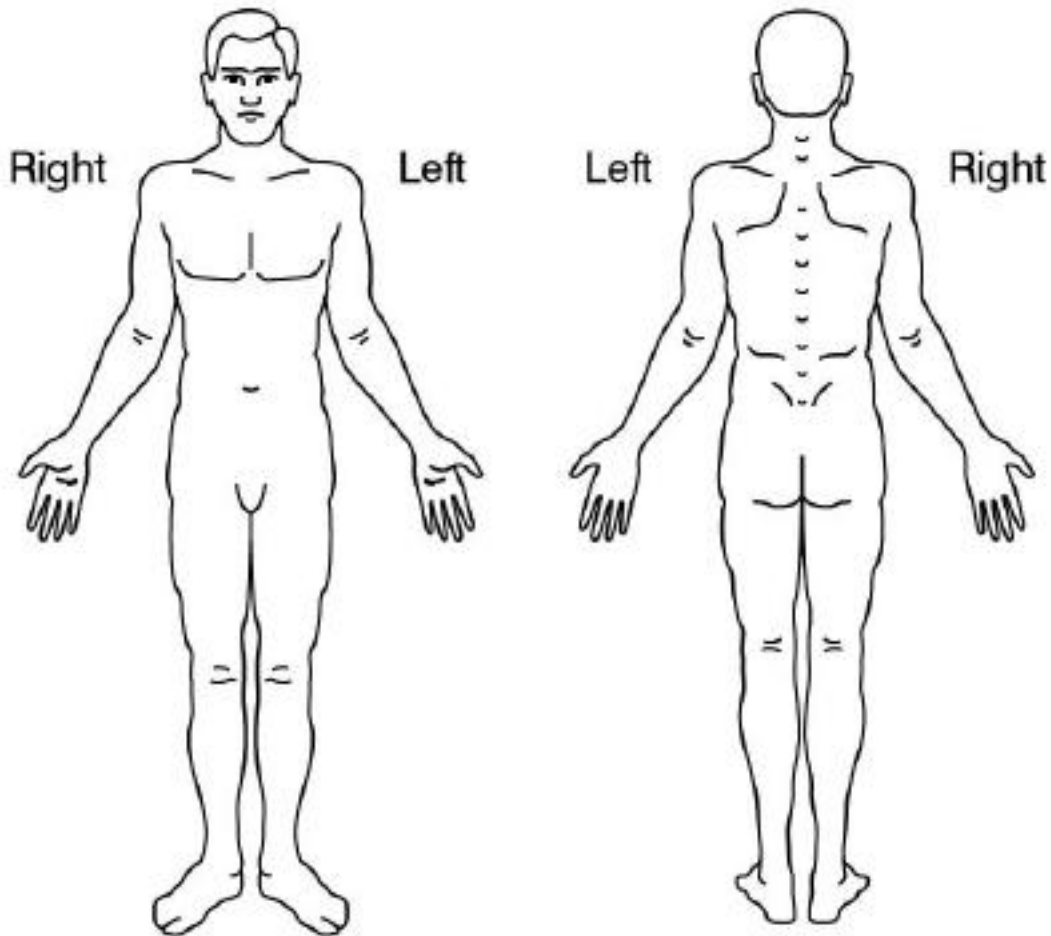
Mark the line to show how much pain you have.

DAY 5

DAY _____

DATE _____

- **Where does it hurt?** (Mark the body drawing to show where it hurts.)



- **Is it always there, or does it come and go?**
- **Is this pain new?**
- **Does the pain move from one place to another?**
- **Where does it travel?**
- **How long does the pain last?**
- **What does the pain feel like?** (burning, gnawing, sharp, etc.)

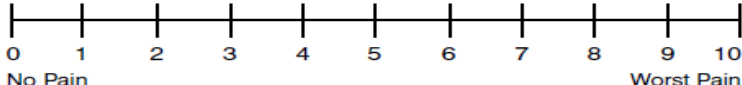
Pain Assessment (Cont.)

- **Where did it start?**
- **How bad is it?**
- **Is there more than one kind of pain?** (Describe each separately.)
- **When do you have pain?** (All the time? Only at night? Other times?)
- **Does the pain interrupt your sleep?**
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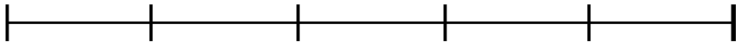


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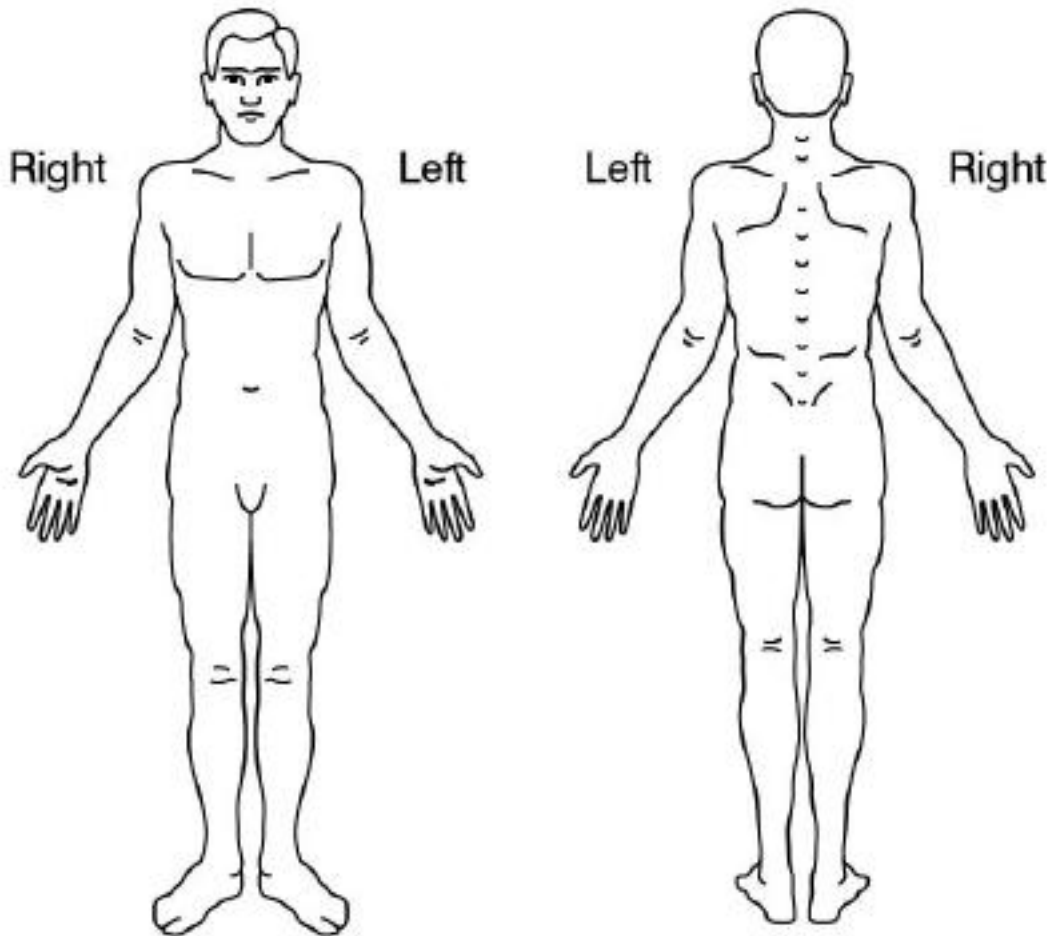
Mark the line to show how much pain you have.

DAY 6

DAY _____

DATE _____

- **Where does it hurt?** (Mark the body drawing to show where it hurts.)



- **Is it always there, or does it come and go?**
- **Is this pain new?**
- **Does the pain move from one place to another?**
- **Where does it travel?**
- **How long does the pain last?**
- **What does the pain feel like?** (burning, gnawing, sharp, etc.)

Pain Assessment (Cont.)

- **Where did it start?**
- **How bad is it?**
- **Is there more than one kind of pain?** (Describe each separately.)
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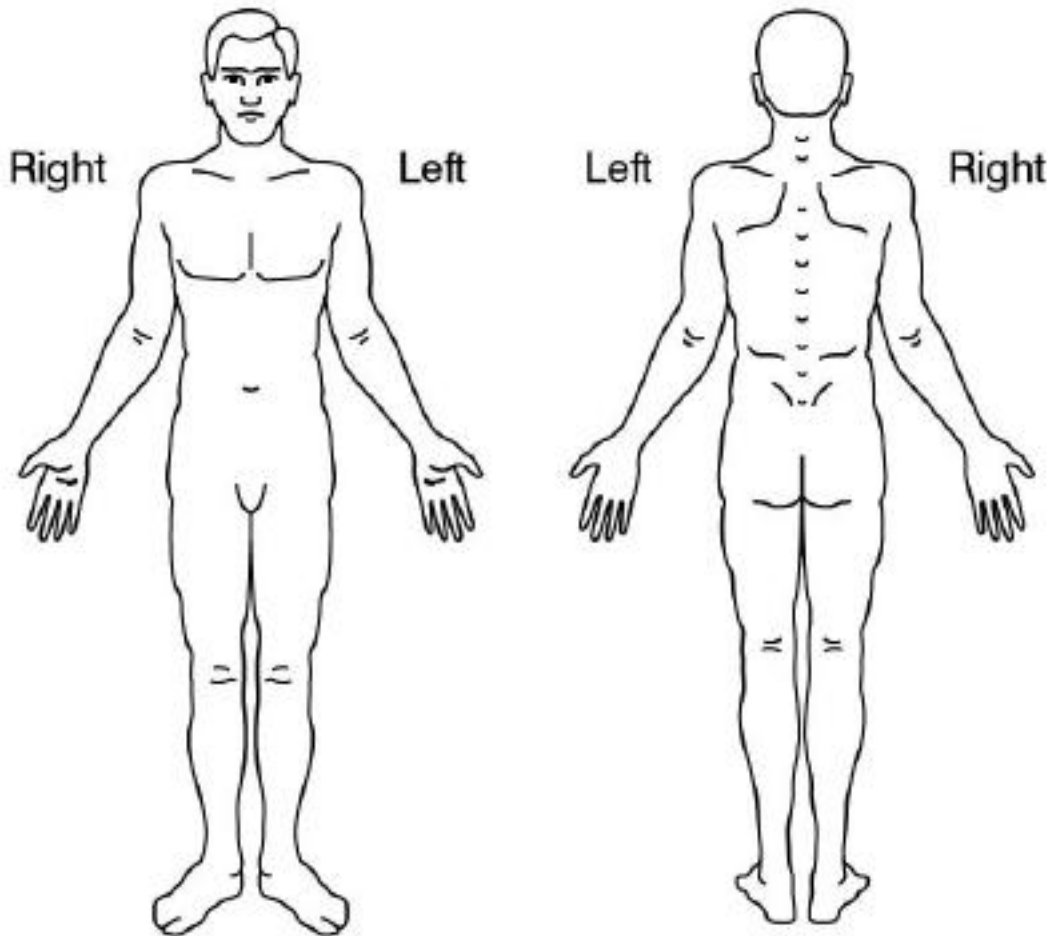
Mark the line to show how much pain you have.

DAY 7

DAY _____

DATE _____

- **Where does it hurt?** (Mark the body drawing to show where it hurts.)



- **Is it always there, or does it come and go?**
- **Is this pain new?**
- **Does the pain move from one place to another?**
- **Where does it travel?**
- **How long does the pain last?**
- **What does the pain feel like?** (burning, gnawing, sharp, etc.)

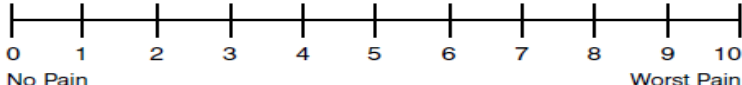
Pain Assessment (Cont.)

- **Where did it start?**
- **How bad is it?**
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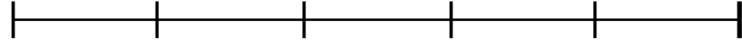


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No Pain Worst Pain

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Pain Distress Scale

None Annoying Uncomfortable Dreadful Horrible Agonizing



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