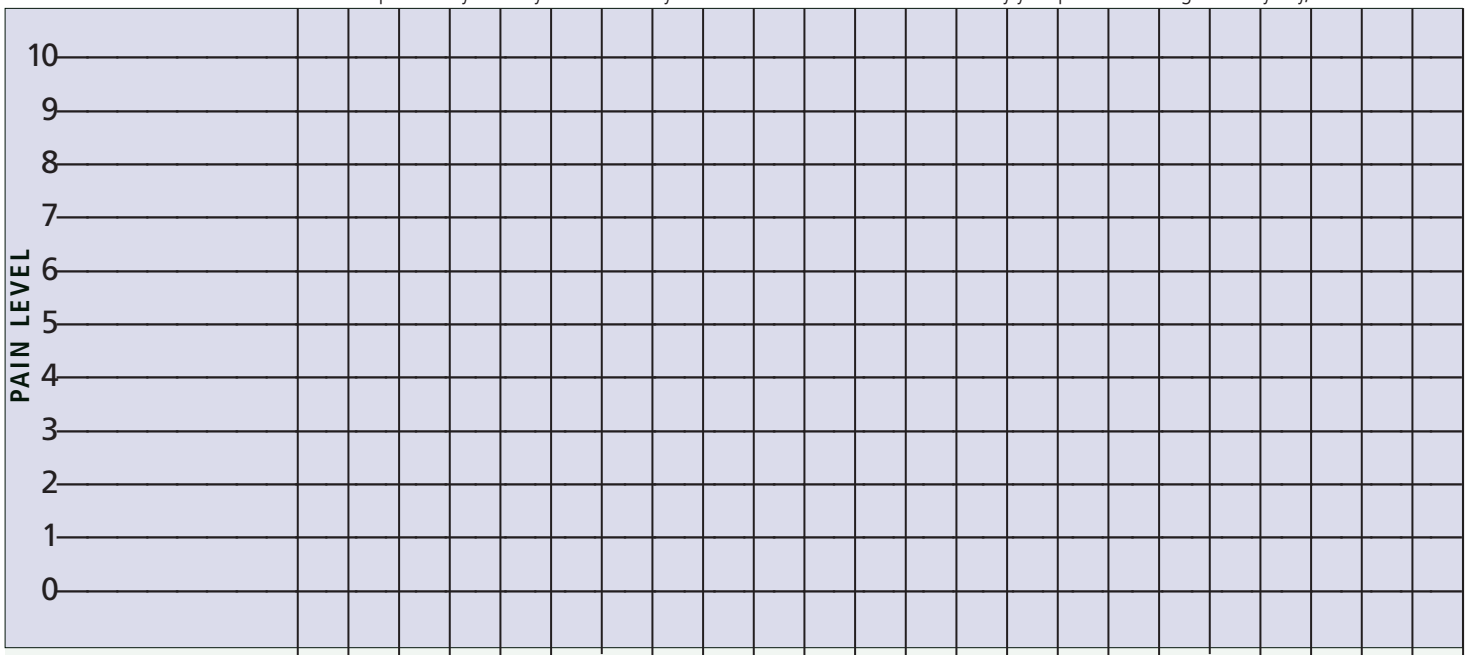
Name _____

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)

#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

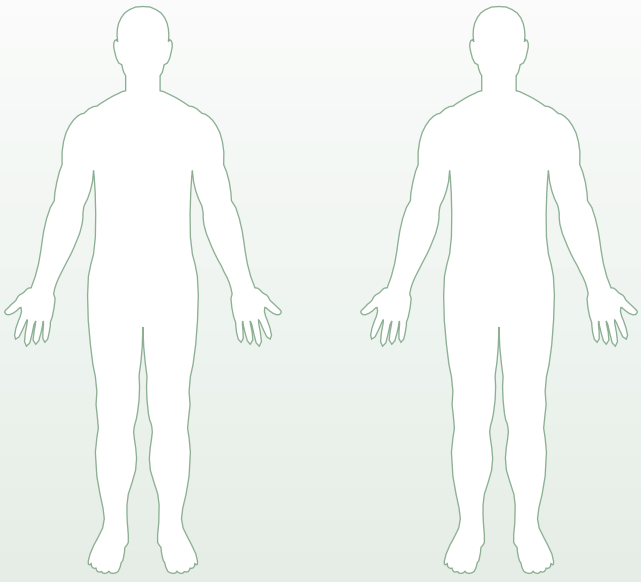
Even though you took your pain medicine for persistent pain on schedule , were there times during the day that you experienced unrelieved breakthrough pain? ____NO ____YES

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