PAIN DIARY Date: _____

On Waking Up: Time:_____Length & Quality of Sleep: _____

Overall Pain Level (1 – 10): _____

Specific Pains & Levels: _____

_____

_____

_____

Mid-Day: Time: _____ Overall Pain Level (1 – 10): _____

Specific Pains & Levels: _____

_____

_____

_____

Afternoon: Time:_____ Overall Pain Level (1 – 10): _____

Specific Pains & Levels: _____

_____

_____

_____

Evening: Time:_____Overall Pain Level (1 – 10): _____

Specific Pains & Levels: _____

_____

_____

_____

Rest/Sleep (circle one)   Rest/Sleep   Rest/Sleep

From:_____To: _____   From:_____To: _____   From:_____To: _____

Exercise

Time:_____   Time:_____   Time:_____

Type:_____   Type:_____   Type:_____

Duration:_____   Duration: _____   Duration: _____

Medication

Type(s): _____ Dose:_____ Time:_____

Type(s): _____ Dose:_____ Time:_____

Type(s): _____ Dose:_____ Time:_____

Type(s): _____ Dose:_____ Time:_____

Type(s): _____ Dose: _____ Time: _____