

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?

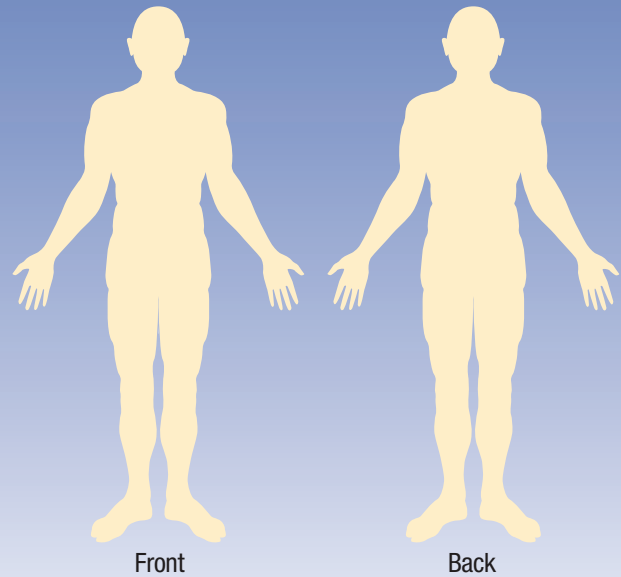
0 1 2 3 4 5 6 7 8 9 10

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.



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