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: _____