Name _____

DOB _____

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

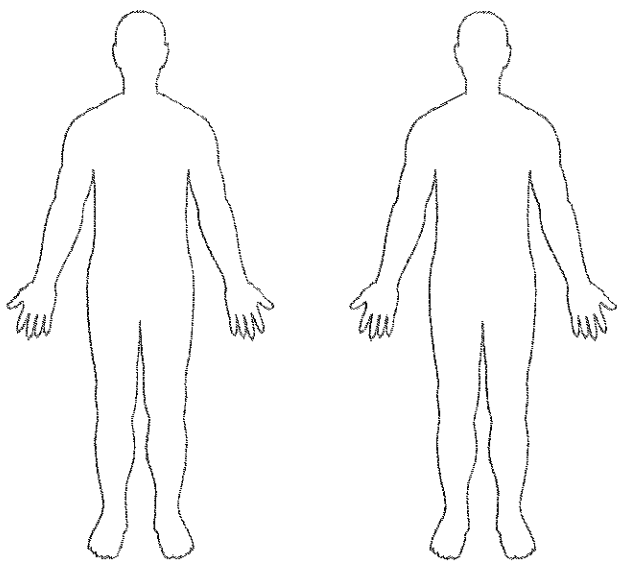
How many times did this happen today?

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.



Front Back

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