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: _____