

Patient _____

Date _____

Pain Log

Track your pain score throughout the day by marking the appropriate box.

Pain Map

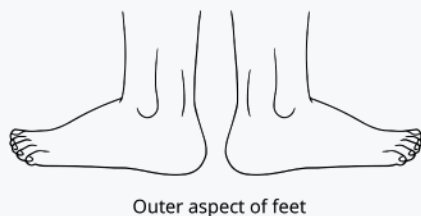
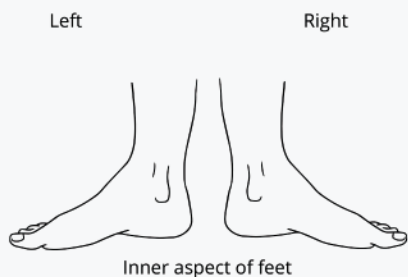
Circle or shade in the location of your pain on the body map.

Pain Questionnaire

Use these questions to help identify additional details about your pain.

Documenting **pain intensity, duration, pattern, location, description and associated factors** can provide invaluable information for both yourself and your pain management team.

Pain Score	Unbearable	10																																						
		9																																						
		8																																						
	Severe	7																																						
		6																																						
		5																																						
	Moderate	4																																						
		3																																						
		2																																						
	Mild	1																																						
		0																																						
		12 AM	1	2	3	4	5	6	7	8	9	10	11	12 PM	1	2	3	4	5	6	7	8	9	10	11															



Pain Description (☑ all that apply)

- Sharp Dull Burning Pressure Aching
- Electric Stabbing Cramping Throbbing Tingling

What makes the pain better? (☑ all that apply)

- Heat Ice Rest Elevation Compression Sleep
- Sitting Standing Stretching Lying Down Exercise
- Medications _____ Other _____

What makes the pain worse? (☑ all that apply)

- Sitting Standing Stretching Inactivity Exercise
- Weather Bending Forward Bending Back Mood
- Stress Coughing Other _____

Are you experiencing any associated symptoms? (☑ all that apply)

- Fever Swelling Tiredness Weakness Bladder Incontinence
- Nausea Vomiting Insomnia Numbness Bowel Incontinence
- Anxiety Depression Other _____

Which activities or functions have been limited by pain? (☑ all that apply)

- Working Sleeping Walking Running Sitting Standing
- Bathing Cleaning Cooking Exercise PT/OT Lifting
- Social events Other _____

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