

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.

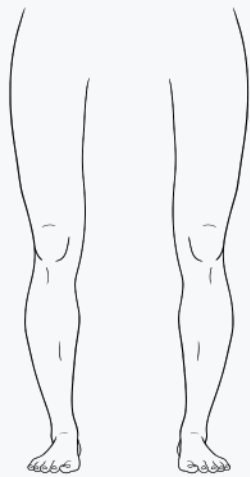
### Pain Questionnaire

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

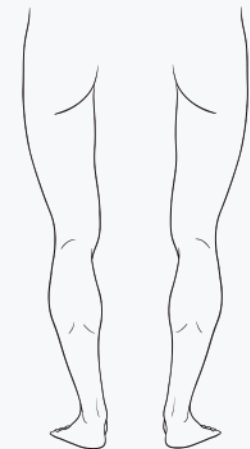
Documenting **pain intensity, duration, pattern, location, description and associated factors** can provide invaluable information for both yourself and your pain management team.

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

Front



Left Right



Back

**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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