My Pain Diary

Fill in all boxes using the numerical scale of:

1 2 3 4 5 6 7 8 9 10
Less More

Week Ending: (dd/mm/yy) ___/___/_____	**Mon**	**Tue**	**Wed**	**Thu**	**Fri**	**Sat**	**Sun**
Morning - Overall Pain Level							
Afternoon - Overall Pain Level							
Evening - Overall Pain Level							
Physical Symptoms							
How well did I sleep?							
How weak do I feel?							
How dizzy / lightheaded do I feel?							
Are my bowel movements normal?							
Is my urination output normal?							
What are my exercise levels?							
Cognitive / Emotional Symptoms							
How is my thinking ability?							
How anxious do I feel?							
How depressed / frustrated am I?							
How angry / irratable am I?							
How happy am I?							
Possible Exacerbating Conditions							
Is the weather affecting me?							
Is the humidity affecting me?							
Have I done too much?							

Comments or Notes: