MY WEEKLY PAIN JOURNAL

Use this pain journal to record your pain, daily activities, and your medications.

If you are experiencing severe pain, call your healthcare provider immediately.

Name

Week Month Year

PLEASE RECORD EACH DAY	TIME OF PAIN • Morning-AM • Afternoon-PM • Night-N • All Day-A	ACTIVITIES CAUSING PAIN • Walking • Sitting • Standing • Bending • Sleeping • List Other	WHERE IS PAIN? • Head • Lower back • Knees/Hips • Hand/Fingers • Legs • Chest • Pelvic Area • List Other	LEVEL OF PAIN On a Scale of 0-10 • 0= no pain • 5= moderate pain • 10= worst pain	1ST MEDICATION • Name of med. • Time taken? (am/pm) • How often? (once daily, every 4 hrs, before bed, etc.) • Level of relief *None* *Some* *Great* • Length of time before feeling relief?	2ND MEDICATION • Name of med. • Time taken? (am/pm) • How often? (once daily, every 4 hrs, before bed, etc.) • Level of relief *None* *Some* *Great* • Length of time before feeling relief?	LIST ADDITIONAL MEDICATIONS, HERBAL REMEDIES, SUPPLEMENTS, ETC.
MON							
TUES							
WED							
THUR							
FRI							
SAT							
SUN							

This form can be downloaded at www.apmhealth.com

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