**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.*

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<table>
<thead>
<tr>
<th>Name</th>
<th>Week</th>
<th>Month</th>
<th>Year</th>
</tr>
</thead>
</table>

**PLEASE RECORD EACH DAY**

<table>
<thead>
<tr>
<th>TIME OF PAIN</th>
<th>ACTIVITIES CAUSING PAIN</th>
<th>WHERE IS PAIN?</th>
<th>LEVEL OF PAIN</th>
<th>1ST MEDICATION</th>
<th>2ND MEDICATION</th>
<th>LIST ADDITIONAL MEDICATIONS, HERBAL REMEDIES, SUPPLEMENTS, ETC.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morning-AM</td>
<td>Walking</td>
<td>Head</td>
<td>On a Scale of 0-10</td>
<td>Name of med.</td>
<td>Name of med.</td>
<td></td>
</tr>
<tr>
<td>Afternoon-PM</td>
<td>Sitting</td>
<td>Lower back</td>
<td>0 = no pain</td>
<td>Time taken? (am/pm)</td>
<td>Time taken? (am/pm)</td>
<td></td>
</tr>
<tr>
<td>Night-N</td>
<td>Standing</td>
<td>Knees/Hips</td>
<td>5 = moderate pain</td>
<td>How often? (once daily, every 4 hrs, before bed, etc.)</td>
<td>How often? (once daily, every 4 hrs, before bed, etc.)</td>
<td></td>
</tr>
<tr>
<td>All Day-A</td>
<td>Bending</td>
<td>Hand/Fingers</td>
<td>10 = worst pain</td>
<td>Level of relief</td>
<td>Level of relief</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sleeping</td>
<td>Legs</td>
<td></td>
<td>None</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Chest</td>
<td></td>
<td>Some</td>
<td>Some</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pelvic Area</td>
<td></td>
<td>Great</td>
<td>Great</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>List Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>List Other</td>
</tr>
</tbody>
</table>

**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
- 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
- Length of time before feeling relief?

**LIST ADDITIONAL MEDICATIONS, HERBAL REMEDIES, SUPPLEMENTS, ETC.**

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This form can be downloaded at PainPhysicians.com

(800) 775-PAIN
PainPhysicians.com