MY PAIN DIARY

TerryWhite Chemmart

DATE & TIME	DESCRIBE YOUR PAIN (e.g. how long it lasts, where it is, whether it moves, what it feels like - dull, sharp, stabbing etc.)	RATE YOUR PAIN (0 = no pain 10 = worst possible pain)	WHAT MADE YOUR PAIN WORSE?	WHAT HELPED YOU GET THROUGH THE DAY? (Medicine and non-medicine such as meditation, exercise etc.)	DESCRIBE YOUR ACTIVITY LEVEL AND MOOD (Has the pain affected your daily life, including sleep, work, social life etc.)	COMMENTS (e.g. problems with your medicines, how your pain affected your day, sleep, mood etc.)