Pain Diary for_____

Date & time	Pain score (0 to 10)	Where pain is and how it feels (ache, sharp, throbbing, shooting, tingling, etc.)	What I was doing when it began	Name and amount of medicine taken	Non-drug techniques I tried	How long the pain lasted	Other notes

0	1	2	3	4	5	6	7	8	9	10
No pain					Moderate pain					Worst pain you've ever had