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 started	Name and amount of medicine, and time it was 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 can imagine