Appendix 8 - Pain Diary

Pain Diary

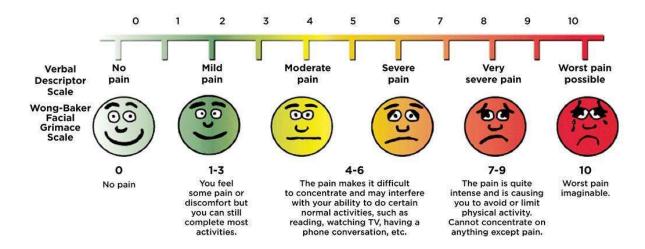
Your doctor, nurse or pharmacist will explain to you how to take your pain relief medications.

This diary will help you and your doctor, nurse or pharmacist to decide whether the pain relief medications you take are suitable for you.

Please fill in the pain diary every time you take your pain relief medication or at least twice a day.

When you fill in your pain intensity, please use the pain assessment tool below to help you describe the pain you are experiencing.

Record your pain intensity just before taking your pain relief medications, take your medications, then wait 30 – 60 minutes and record your pain intensity again.



Please keep a note of any side effects that your pain relief medications cause and how the pain is affecting your daily activities such as stopping you doing activities, or limiting how far you can walk.

Please bring the completed pain diary to the next appointment for your pain. You and your doctor, nurse or pharmacist can use the information you record to decide if your pain relief medications are right for you.

Date and time	Name of medication and dose taken	Pain intensity before taking pain relief	Pain intensity after taking pain relief	Any side effects? What are they?	Is your pain affecting daily activity? In what way?	Was my sleep disturbed by pain?
1 1						
am						
pm						
/ /						
am						
pm						
/ /						
am						
pm						
/ /						
am						
pm						
/ /						
am						
pm						
/ /						
am						
pm						
/ /						
am						
pm						
/ /						
am						
pm						
/ /						
am						
pm						

Date and time	Name of medication and dose taken	Pain intensity before taking pain relief	Pain intensity after taking pain relief	Any side effects? What are they?	Is your pain affecting daily activity? In what way?	Was my sleep disturbed by pain?
1 1						
am						
pm						
/ /						
am						
pm						
/ /						
am						
pm						
/ /						
am						
pm						
/ /						
am						
pm						
/ /						
am						
pm						
/ /						
am						
pm						
/ /						
am						
pm						
/ /						
am						
pm						

Date and time	Name of medication and dose taken	Pain intensity before taking pain relief	Pain intensity after taking pain relief	Any side effects? What are they?	Is your pain affecting daily activity? In what way?	Was my sleep disturbed by pain?
1 1						
am						
pm						
am						
pm						
am						
pm						
1 1						
am						
pm						
am						
pm						
am						
pm						
/ /						
am						
pm						
am						
pm						
am						
pm						