Date of initial review						
Pain score						
ACTION PLAN include follow up date						
Review date and pain score						



## Pain Diary

Please fill this card in every day and bring it back for next appointment

NAME of

PATIENT	
Address	
Date of Birth	
PHARMACIST	
Address	
Telephone	
DOCTOR	
Address	
Telephone	

**PAIN DIARY** Note perception of pain on scale 1-10 each day at different times of the day and note any comments e.g. extra painkillers taken, specific activity e.g. gardening

0 = no pain 1-3 = occasional mild pain. I can live with symptoms 4-5 = Moderate pain which limits some activities 6-10 = Severe pain present. Activities and concentration markedly affected

			MON	TUE	WED	THU	FRI	SAT	SUN
Week 1	Pain level	Morning							
		Evening							
	Comments								
Week 2	Pain level	Morning							
		Evening							
	Comments								
Week 3	Pain level	Morning							
		Evening							
	Comments								
Week 4	Pain level	Morning							
		Evening							
	Comments								