

Name _____

Record Started on _____

My Pain Assessment Diary

"It's your health—you can take charge!"

Developed by
Abbotsford & Mission
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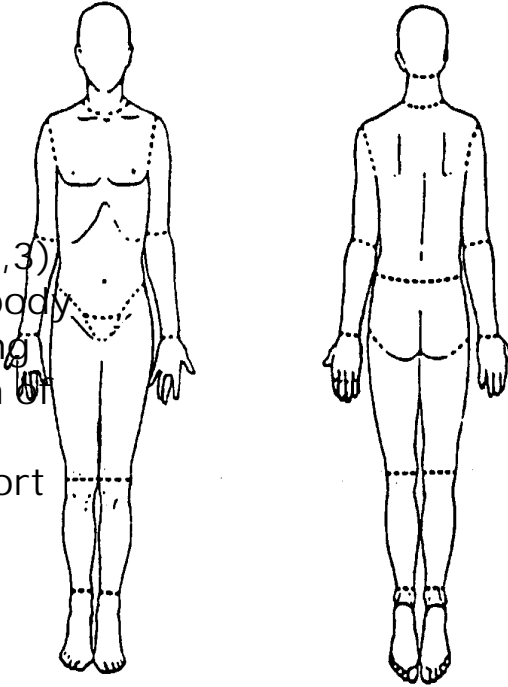


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Best in health care.

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Questions to ask my Doctor

Place a number
(e.g. 1,2,3)
On the body
indicating
Location of
pain or
discomfort



10 → ← Extreme Pain
9 → ← Severe Pain
8 → ← Moderate Pain
7 → ← Mild Pain
6 → ← Slight Pain
5 → ← No pain
4 →
3 →
2 →
1 →
0 →

The image shows a vertical thermometer graphic. The bulb at the bottom is shaded. To the left of the thermometer, numbers 10 through 0 are listed with arrows pointing to the right. To the right of the thermometer, corresponding pain levels are listed with arrows pointing to the left. The levels are: 10 - Extreme Pain, 9 - Severe Pain, 8 - Moderate Pain, 7 - Mild Pain, 6 - Slight Pain, and 0 - No pain. There are also blank arrows pointing left for numbers 5, 4, 3, and 2.

Other ways to help manage my pain:

- ◆ Heat cold
- ◆ Relaxation
- ◆ Music
- ◆ Gentle massage or rubbing
- ◆ Distraction
- ◆ Reading
- ◆ Comfortable positions
- ◆ Emotional support
- ◆ Pets
- ◆ Exercise/physical therapy
- ◆ Laughter/humor
- ◆ Visitors

How would you describe your pain?

“Pain is what you say it is and occurs when you say it does”.

Discomfort

Dull ache

Sharp

Burning

Pins and needles

Stabbing

Cramping

Throbbing

Shooting

Electric Like

Surface

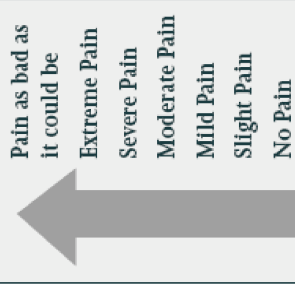
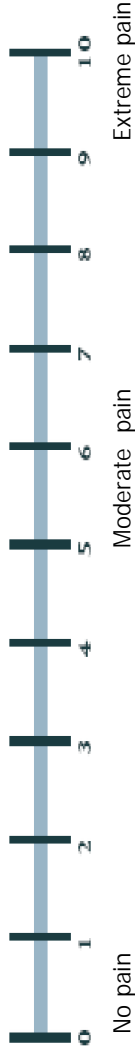
Deep

Constant

Occasional

Other

Daily Pain Diary and Pain Scale



Use this diary to record your pain and what you did to treat it. This will help your health care provider to understand your pain better. Fill in the information and bring the journal With you to your next appointment. If your pain is not relieved by your treatment, call your Health care provider.

Date Time	Where is the pain? Rate the pain (0-10), or list the word from the scale that describes your pain.	What were you doing when the pain started or increased?	Did you take medicine? What did you take? How much?	What other treatments did you use?	After an hour, what is your pain rating?	Side effects? Constipation (C) Nausea (N)

U – Understanding: What do you understand about this pain? What does having this “pain” or “discomfort” mean? _____

V – Values /Concerns: What do you hope / expect in relation to this pain or discomfort? _____

Other comments - include comments from family or friends _____

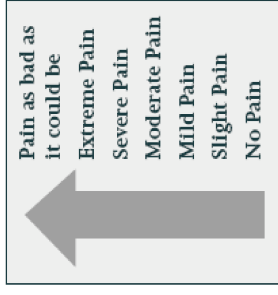
Daily Pain Diary and Pain Scale



No pain

Moderate pain

Extreme pain



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