Hope Recovery
PO Box 411
Clinton, IN 47842
recovery@hope4-recovery.org
(765) 505-8908

Monthly Pain Diary * Month _____

Rate each * question each day with the following scale of 1 to 10, with 0 being none, and 10 being the most severe.

0 = ☺ 10 = ☹

*Morning Overall Pain																														
*Afternoon Overall Pain																														
*Evening Overall Pain																														
DAYS of the MONTH	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**	**31**
Write a brief summary of your pain experience each day.																														
Notes/Questions for your Physician																														

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Monthly Pain Questions * Month: _____

Rate each * question each day with the following scale of 1 to 10, with 0 being none, and 10 being the most severe.

Answer each # question each day with a Y for yes or N for No. 0 = ☺ 10 = ☹

#Have I avoided any of my activities or canceled plans today because of changes in my pain?																														
#Did I take all my pain meds today as instructed?																														
#Were there times I experienced unrelieved break through pain?																														
How many times did this happen?																														
DAYS of the MONTH	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**	**31**
#Did I sleep thru the night?																														
How many times was my sleep interrupted because of pain?																														
*How weak do I feel?																														
*How dizzy do I feel?																														
#Are my bowel movements normal?																														
#Is my urine output normal?																														
DAYS of the MONTH	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**	**19**	**20**	**21**	**22**	**23**	**24**	**25**	**26**	**27**	**28**	**29**	**30**	**31**
*How is my thinking ability with my pain?																														
*How anxious do I feel due to pain?																														
*How depressed / irritated am I due to pain?																														