solis
INTEGRATIVE
HEALTH CENTRE

PAIN DIARY
Tel/Fax: 778-774-7442

Name: _____ Date: _____

Informed Consent: YES: ◯ NO: ◯

PROCEDURE: _____

MEDICATION: _____

Pain Scale 0-10		PRE	POST	1HR	2HR	4HR	6HR	DAY1	DAY2	DAY3	DAY4	DAY5	DAY6	DAY7	WEEK2	WEEK3	WEEK4	MONTH2	MONTH3
Unbearable	10																		
	9																		
Severe	8																		
	7																		
Uncomfortable	6																		
	5																		
Functional	4																		
	3																		
Mild	2																		
	1																		
No Pain	0																		

OVERALL PAIN IS: Much worse ◯ Slightly Worse ◯ Not Changed ◯ Slightly Better ◯ Much Better ◯

MY NEED FOR MEDICATION: Much increased ◯ Slight increase ◯ Not Changed ◯ Slightly Less ◯ Much Less ◯

SIDE EFFECTS: _____

PATIENT COMMENTS: _____

PHYSICIAN COMMENTS: _____