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PATIENT PAIN DIARY

Patient Name: _____ **Date of Birth:** _____ **Date Issued:** _____ **Date Received:** _____

Today's date	Time	Rate pain from 0-10 *(see pain scale)*	Where is the pain located	Describe the pain (i.e. sharp, stabbing, aching, etc	What mediction did you take? How much medicine did you take	Other than medication, what other treatment did you use?	Describe your activity level at the time

____0_____ 1_____ 2_____ 3_____4_____5_____5_____7_____8_____9_____ 10____

0 = No pain 1-3 = Least pain 4-6 =Mild to moderate pain 7-8 = Severe pain 9-10 = Excruciating pain