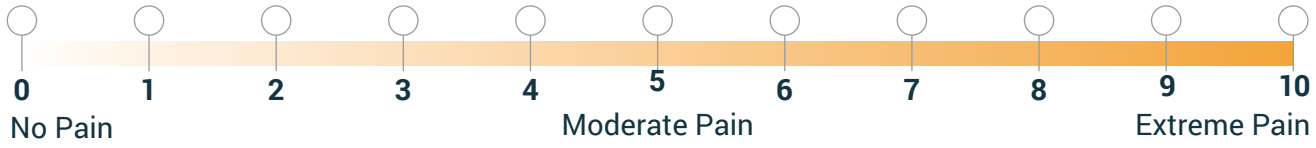
Daily Pain Diary

Date:

Intensity of Pain:



Type of Pain:

- ○ Aching
- ○ Burning
- ○ Pins and Needles
- ○ Shooting
- ○ Squeezing
- ○ Stabbing

Time of Pain:

- ○ AM
- ○ PM
- ○ All day

Site of Pain:

Activity at Time of Pain:

Prescription Medications Taken:

Dosage:

Relief: ○ None ○ Some ○ Complete

Supplements Taken:

Appointments:

○ Chemotherapy ○ Immunotherapy ○ Radiation

Over-the-Counter Medications Taken:

Dosage:

Relief: ○ None ○ Some ○ Complete

Other Notes:

Alternative Treatments:

Relief: ○ None ○ Some ○ Complete