# FAST FACTS: Using a Pain Diary

A Pain Diary is used to monitor pain over time, collect data on possible pain triggers and provide information for a healthcare provider to make best treatment decisions. It is often said the patient is the most important person in the pain management process, however if the patient is unable to share information about their pain experience or maintain a Pain Diary this important task is often assumed by the caregiver.

- ✓ **Why to complete a Pain Diary**
  - Primary Care Provider (PCP) or Specialist has asked you to track pain
  - Provides a written history of pain issues that can be shared with the healthcare provider and can support better treatment decision.
- ✓ **When to complete a Pain Diary**
  - On a routine basis to track pain, preferably daily
  - For additional acute pain episodes as they occur
- ✓ **What to track on a Pain Diary**
  - Date/Time
  - Location of pain
  - Intensity of pain
  - Impact of pain on function
  - Aggravating factors (what were they doing when pain started/increased?)
  - Treatments tried
  - Other problems or side effects

**PAIN DIARY EXAMPLE**

**CAREGIVER PAIN DIARY**

| **Date/ Time** | **Pain Location** (Note any areas causing pain) | **Self-Report Pain Rating** *(0-10)* | **PAINAD Score** no self-report *(0-10)* | **What triggered the pain report or behaviors?** | **Treatments Tried** medicine (specify drug and dose) non-drug treatment (e.g. heat, cold, exercise, massage, distraction, music, splinting) | **Pain Rating** 1hr after treatment *(0-10)* | **Additional Comments** |
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