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 that you are the most important person in the pain management process.

If you are able to self-report, you should provide information for the Pain Diary. However, if you are unable to share information about your pain experience or maintain a Pain Diary this important task is often assumed by your caregiver.

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

PAIN DIARY EXAMPLE

PAIN DIARY

Use the rating scales provided on page 1 to determine your Pain Rating, Pain Interference (PI)- Enjoyment of Life, and Pain Interference (PI)- General Activity.
Document your pain experience at least once per day, unless you identify a new/different pain (i.e. a new location, etc.), then document each unique situation.

Date/Time	Pain Location	Pain Rating (0-10)	PI- Enjoyment of Life (0-10)	PI- General Activity (0-10)	What triggered your pain?	Treatments Tried (i.e. medicine; extra pain medicine; non-drug treatment such as: heat, cold, meditation, PT, etc.)	After 1-hour Pain Rating (0-10)

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