Pain Management Diary

NAME: __________________________  DATE: __________________________

Please check who completed this form: □ Self  □ Caregiver (with older adult’s answers)

1. Any new pain or change in pain today?  Yes  No

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Pain</td>
<td>Mild Pain</td>
<td>Moderate Pain</td>
<td>Severe Pain</td>
<td>Worst Pain Imaginable</td>
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</table>

2. Using the scale above, choose the number that best describes:

- The average amount of pain you’ve experienced today. ________________
- The worst amount of pain you’ve experienced today. ________________

3. Today, my pain is:  □ Constant  □ Comes and Goes  □ Constant, but gets worse at times

4. In the last 24 hours, how much relief have pain treatments (non-drug strategies) or medications provided? Please choose the one percentage from below that most shows how much relief you have received.

<table>
<thead>
<tr>
<th>0%</th>
<th>10%</th>
<th>20%</th>
<th>30%</th>
<th>40%</th>
<th>50%</th>
<th>60%</th>
<th>70%</th>
<th>80%</th>
<th>90%</th>
<th>100%</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Relief</td>
<td>Complete Relief</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

5. Please check any non-drug strategies you used today to help manage your pain.

□ Changing Position  □ Heat  □ Cold  □ Rest  □ Physical therapy
□ Massage  □ Music  □ Relaxation  □ Distraction  □ Prayer/Meditation
□ Exercise/Walking  □ Over the counter ointments (e.g. Ben Gay®, Icy Hot®, etc)
6. In the last 24 hours, did you experience any of the following: (Check all that apply)

☐ nausea ☐ vomiting ☐ diarrhea ☐ constipation ☐ shortness of breath

☐ itching ☐ fatigue ☐ confusion ☐ heartburn ☐ excessive sweating

☐ weakness ☐ bloating ☐ sore mouth ☐ difficulty concentrating or remembering things

☐ excessive sleepiness ☐ difficulty sleeping ☐ inability to urinate ☐ bad dreams

☐ difficulty swallowing ☐ loss of appetite ☐ abdominal pain ☐ swelling of hands or feet

7. If you skipped any pain medications today, why? ________________________________

8. Comments: (helpful information would include any changes you have noticed lately: in pain relief, side effects, location or quality of your pain, need for more/less medication, what would help you be more comfortable...)

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