Pain Journal / Log

Name:______________________ Date of Birth: ______________________

Date	Time	Pain Score (0-10)*	Location of Pain and How It Feels (sharp, shooting, needles, etc.)	How Long It Lasted	Non-Medication Treatment (sleep, ice,	Medication and Dosage	Other Notes Regarding Activities / Events (e.g. weather, social activities, triggers, etc.)

* Pain Score: 0 is no pain; 1 is mild pain; 5 is medium pain; and 10 is the worst pain which may require a hospital visit.