

Date : \_\_\_\_\_

From 1 to 10 (low to high) note your general overall pain level

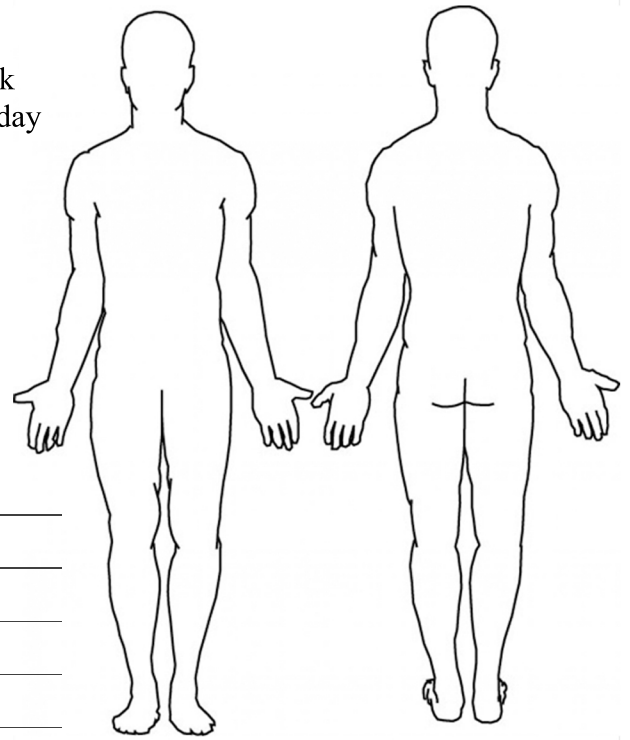
Using the figure, mark all places that hurt today

Morning :

Afternoon :

Evening :

S = Shooting Pain  
 X = Stabbing Pain  
 B = Burning Pain  
 N = Numbness  
 A = Aching  
 P = Pins & Needles



NOTES

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From 1 to 10 (low to high) fill in below

How well did I sleep

How are my bowel movements

How depressed am I

What is my fatigue level

How is my walking

How angry do I feel

How weak do I feel

How stiff do I feel

How irritable am I

How dizzy do I feel

How sensitive am I

How happy am I

How is my eyesight

How is my thinking ability

How stressed am I

How is my hearing

How anxious do I feel

How overwhelmed am I

6am	7am	8am	9am	10am	11am	12pm	1pm	2pm	3pm	4pm	5pm	6pm	7pm	8pm	9pm	10pm	11pm

KEY

Rest

Low Activity

Medium Activity

High Activity