

DAILY PAIN JOURNAL

Date: _____

Time	Activity	Pain Rating (0-10)	Pain Medication(s) Taken (Yes/No)	Other Pain Relief Methods Used (list)
a.m. 12:00				
1:00				
2:00				
3:00				
4:00				
5:00				
6:00				
7:00				
8:00				
9:00				
10:00				
11:00				
p.m. 12:00				
1:00				
2:00				
3:00				
4:00				
5:00				
6:00				
7:00				
8:00				
9:00				
10:00				
11:00				

Date/ Time	Severity of Fatigue 0-10 (where 0 means no fatigue and 10 means the worst fatigue imaginable)	Level of Interference with Daily Activities 0-10 (e.g. grooming & shopping)	Anything Done to Relieve Fatigue

Factors that Make Fatigue Worse (emotional & physical):

Factors that Improve Symptoms of Fatigue:
