

# MY PAIN DIARY

---

**Name**

---

**Date of issue**

---



Grünenthal GmbH · 52099 Aachen  
Germany · [www.grunenthal.com](http://www.grunenthal.com)





# The importance of keeping a pain diary

Dear patient,

Pain can come from many causes and everyone is affected differently by it. Because of this, it's very important that your treatment plan is tailored to you and how you're feeling.

The first step to change pain is to take your medicine exactly as your doctor has suggested. To make sure that it's right for you and working as best as it can for your pain condition, it's just as important that you keep track of how well it is working.

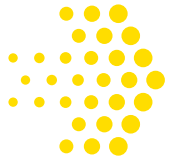
This is why you have been given this pain diary. With this, you can easily note down how you feel each day, whether you are coping, the level of pain you are experiencing and any side effects. You should try to write in this diary a few times a day so that your doctor can see how well the medicine is working and make changes to fix anything that is not working so well.

Please bring this diary at your next visit. Your doctor will go through it with you and discuss the next steps.

We wish you the very best for your treatment!

You can also find other patient support material at [www.change-pain.com](http://www.change-pain.com).

Your CHANGE PAIN® Team



# Your current treatments

Treatment*	Prescription date	Regular	Changes	Daily dose	Side effects

\*For example, medication to treat your pain, co-medication to manage side effect, physical or occupational therapy, exercise.



# Therapeutic goals


























Date of visit \_\_\_\_\_

	No pain at all <b>0</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>	The worst pain imaginable <b>10</b>
<b>Current pain level</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<b>Acceptable pain level</b>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

	Not at all	A little	Very much
<b>What needs improving?</b> Sleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mobility	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Mood	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>




























# How do I feel today?

Week _____ 	Monday			Tuesday			Wednesday			Thursday			Friday			Saturday			Sunday		
Medication taken at	8 am	12 pm	6 pm	8 am	12 pm	6 pm	8 am	12 pm	6 pm	8 am	12 pm	6 pm	8 am	12 pm	6 pm	8 am	12 pm	6 pm	8 am	12 pm	6 pm
	8 am			8 am			8 am			8 am			8 am			8 am			8 am		
	12 pm			12 pm			12 pm			12 pm			12 pm			12 pm			12 pm		
For each time of day, please rate your level of pain on a scale of 0-10, 0 being no pain at all, and 10 being the worst pain imaginable	6 pm			6 pm			6 pm			6 pm			6 pm			6 pm			6 pm		
Side effects/impairments	  			  			  			  			  			  			  		
_____ 																					
_____ 																					
_____ 																					
Sleep																					
Mobility																					
Mood																					




























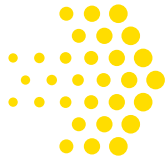
# How do I feel today?

Week _____ 	Monday			Tuesday			Wednesday			Thursday			Friday			Saturday			Sunday		
Medication taken at	8 am	12 pm	6 pm	8 am	12 pm	6 pm	8 am	12 pm	6 pm	8 am	12 pm	6 pm	8 am	12 pm	6 pm	8 am	12 pm	6 pm	8 am	12 pm	6 pm
For each time of day, please rate your level of pain on a scale of 0-10, 0 being no pain at all, and 10 being the worst pain imaginable	8 am			8 am			8 am			8 am			8 am			8 am			8 am		
	12 pm			12 pm			12 pm			12 pm			12 pm			12 pm			12 pm		
	6 pm			6 pm			6 pm			6 pm			6 pm			6 pm			6 pm		
Side effects/impairments	  			  			  			  			  			  			  		
_____ 																					
_____ 																					
_____ 																					
Sleep																					
Mobility																					
Mood																					




























# How do I feel today?

Week _____ 	Monday			Tuesday			Wednesday			Thursday			Friday			Saturday			Sunday					
Medication taken at	8 am	12 pm	6 pm	8 am	12 pm	6 pm	8 am	12 pm	6 pm	8 am	12 pm	6 pm	8 am	12 pm	6 pm	8 am	12 pm	6 pm	8 am	12 pm	6 pm			
	8 am			8 am			8 am			8 am			8 am			8 am			8 am					
	12 pm			12 pm			12 pm			12 pm			12 pm			12 pm			12 pm					
For each time of day, please rate your level of pain on a scale of 0-10, 0 being no pain at all, and 10 being the worst pain imaginable	6 pm			6 pm			6 pm			6 pm			6 pm			6 pm			6 pm					
	Side effects/impairments			  			  			  			  			  			  			  		
	_____ 																							
_____ 																								
_____ 																								
Sleep																								
Mobility																								
Mood																								



# How do I feel today?

Week _____ 	Monday			Tuesday			Wednesday			Thursday			Friday			Saturday			Sunday		
Medication taken at	8 am	12 pm	6 pm	8 am	12 pm	6 pm	8 am	12 pm	6 pm	8 am	12 pm	6 pm	8 am	12 pm	6 pm	8 am	12 pm	6 pm	8 am	12 pm	6 pm
	8 am			8 am			8 am			8 am			8 am			8 am			8 am		
	12 pm			12 pm			12 pm			12 pm			12 pm			12 pm			12 pm		
For each time of day, please rate your level of pain on a scale of 0-10, 0 being no pain at all, and 10 being the worst pain imaginable	6 pm			6 pm			6 pm			6 pm			6 pm			6 pm			6 pm		
Side effects/impairments	  			  			  			  			  			  			  		
_____ 																					
_____ 																					
_____ 																					
Sleep																					
Mobility																					
Mood																					