Patient Name: **Date of Birth:** **Date Given:**

This pain journal MUST be turned in every month in order to receive your new narcotic medication prescription.	Medications:

In an effort to better assess your pain on a daily basis, please use this diary to record how you feel. Your own self-assessment is the best way for your physician to evaluate the effectiveness of your pain management program.

Please also take the time to record the date, time, and activity related to any incident pain that you experience.

Date	Time	Daily Activities	Rate your pain (0-10)	Medication and dosage taken for breakthrough pain (if applicable)	Comments

Reviewed by physician: Date: