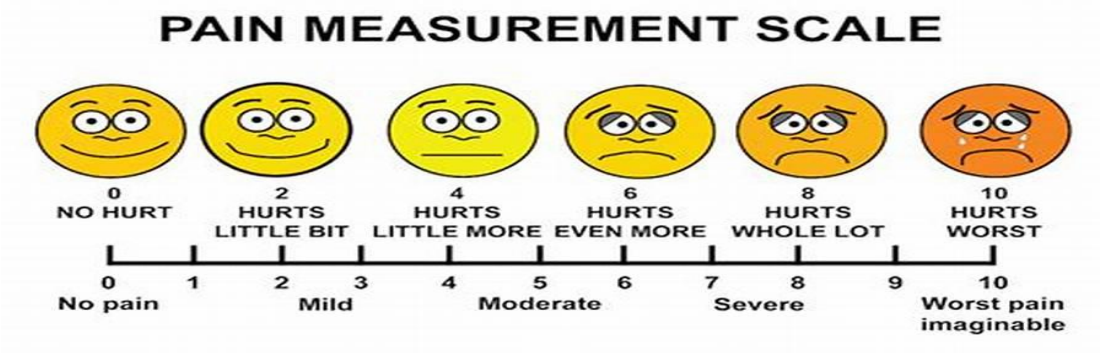
MY COMMUNITY HEALTH CENTER



Pain Diary

Daye & Time	Pain Score (0-10)	Name & Amount of Medication Taken	Where is the pain & how does it feel? (Ache, Sharp, Throbbing, Shooting, Tingling, etc.)	Non-Drug Techniques I Tried	Did you have pain relief? If yes, for how long?