

Injury Pain Journal

A simple daily log | Forman & Associates | 502-931-6788

Your information

Name: _____

Date of injury: _____

How the injury happened: _____

Doctors and clinics: _____

Medications: _____

How to use this journal

- Fill in one page each day, at about the same time. It takes about two minutes.
- Rate your pain from 0 (no pain) to 10 (worst pain imaginable) in the morning, afternoon and evening.
- Be specific: "could not lift the laundry basket" says more than "bad day."
- Write good days too. An honest record shows both setbacks and improvement.
- Do not go back and fill in missed days from memory. Just start again.
- Stick to facts. Others, including an insurance company, may read this journal someday.
- Tell your doctor about new or worse symptoms. This journal does not replace medical care.
- Keep receipts and mileage for medical trips with this journal.

Pain scale

0	1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	---	----

0 = no pain

5 = hard to ignore, limits activity

10 = worst imaginable

Pain level (circle 0-10)

Morning	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩	Where: _____
Afternoon	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩	Where: _____
Evening	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩	Where: _____

Sleep: hours slept _____ times woken by pain _____**Medications taken (name, dose, time)**

Appointments, therapy or treatment today

Work: [] worked full day [] partial day: _____ hours missed [] missed whole day [] not working**Things I could not do or needed help with today**

Mood, sleep, stress or other symptoms

Expenses today (medical, mileage, help at home)

Pain level (circle 0-10)

Morning	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩	Where: _____
Afternoon	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩	Where: _____
Evening	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩	Where: _____

Sleep: hours slept _____ times woken by pain _____**Medications taken (name, dose, time)**

Appointments, therapy or treatment today

Work: [] worked full day [] partial day: _____ hours missed [] missed whole day [] not working**Things I could not do or needed help with today**

Mood, sleep, stress or other symptoms

Expenses today (medical, mileage, help at home)

Pain level (circle 0-10)

Morning	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10	Where: _____
Afternoon	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10	Where: _____
Evening	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10	Where: _____

Sleep: hours slept _____ times woken by pain _____

Medications taken (name, dose, time)

Appointments, therapy or treatment today

Work: ☐ worked full day ☐ partial day: _____ hours missed ☐ missed whole day ☐ not working

Things I could not do or needed help with today

Mood, sleep, stress or other symptoms

Expenses today (medical, mileage, help at home)

Pain level (circle 0-10)

Morning	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩	Where: _____
Afternoon	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩	Where: _____
Evening	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩	Where: _____

Sleep: hours slept _____ times woken by pain _____**Medications taken (name, dose, time)**

Appointments, therapy or treatment today

Work: [] worked full day [] partial day: _____ hours missed [] missed whole day [] not working**Things I could not do or needed help with today**

Mood, sleep, stress or other symptoms

Expenses today (medical, mileage, help at home)

Pain level (circle 0-10)

Morning	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩	Where: _____
Afternoon	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩	Where: _____
Evening	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩	Where: _____

Sleep: hours slept _____ times woken by pain _____**Medications taken (name, dose, time)**

Appointments, therapy or treatment today

Work: [] worked full day [] partial day: _____ hours missed [] missed whole day [] not working**Things I could not do or needed help with today**

Mood, sleep, stress or other symptoms

Expenses today (medical, mileage, help at home)

Pain level (circle 0-10)

Morning	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩	Where: _____
Afternoon	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩	Where: _____
Evening	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩	Where: _____

Sleep: hours slept _____ times woken by pain _____**Medications taken (name, dose, time)**

Appointments, therapy or treatment today

Work: [] worked full day [] partial day: _____ hours missed [] missed whole day [] not working**Things I could not do or needed help with today**

Mood, sleep, stress or other symptoms

Expenses today (medical, mileage, help at home)

Pain level (circle 0-10)

Morning	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩	Where: _____
Afternoon	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩	Where: _____
Evening	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩	Where: _____

Sleep: hours slept _____ times woken by pain _____**Medications taken (name, dose, time)**

Appointments, therapy or treatment today

Work: [] worked full day [] partial day: _____ hours missed [] missed whole day [] not working**Things I could not do or needed help with today**

Mood, sleep, stress or other symptoms

Expenses today (medical, mileage, help at home)

Pain level (circle 0-10)

Morning	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩	Where: _____
Afternoon	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩	Where: _____
Evening	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩	Where: _____

Sleep: hours slept _____ times woken by pain _____**Medications taken (name, dose, time)**

Appointments, therapy or treatment today

Work: [] worked full day [] partial day: _____ hours missed [] missed whole day [] not working**Things I could not do or needed help with today**

Mood, sleep, stress or other symptoms

Expenses today (medical, mileage, help at home)

Pain level (circle 0-10)

Morning	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩	Where: _____
Afternoon	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩	Where: _____
Evening	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩	Where: _____

Sleep: hours slept _____ times woken by pain _____

Medications taken (name, dose, time)

Appointments, therapy or treatment today

Work: [] worked full day [] partial day: _____ hours missed [] missed whole day [] not working

Things I could not do or needed help with today

Mood, sleep, stress or other symptoms

Expenses today (medical, mileage, help at home)

Pain level (circle 0-10)

Morning	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩	Where: _____
Afternoon	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩	Where: _____
Evening	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩	Where: _____

Sleep: hours slept _____ times woken by pain _____**Medications taken (name, dose, time)**

Appointments, therapy or treatment today

Work: [] worked full day [] partial day: _____ hours missed [] missed whole day [] not working**Things I could not do or needed help with today**

Mood, sleep, stress or other symptoms

Expenses today (medical, mileage, help at home)

Pain level (circle 0-10)

Morning	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩	Where: _____
Afternoon	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩	Where: _____
Evening	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩	Where: _____

Sleep: hours slept _____ times woken by pain _____**Medications taken (name, dose, time)**

Appointments, therapy or treatment today

Work: [] worked full day [] partial day: _____ hours missed [] missed whole day [] not working**Things I could not do or needed help with today**

Mood, sleep, stress or other symptoms

Expenses today (medical, mileage, help at home)

Pain level (circle 0-10)

Morning	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩	Where: _____
Afternoon	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩	Where: _____
Evening	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩	Where: _____

Sleep: hours slept _____ times woken by pain _____**Medications taken (name, dose, time)**

Appointments, therapy or treatment today

Work: [] worked full day [] partial day: _____ hours missed [] missed whole day [] not working**Things I could not do or needed help with today**

Mood, sleep, stress or other symptoms

Expenses today (medical, mileage, help at home)

Pain level (circle 0-10)

Morning	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩	Where: _____
Afternoon	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩	Where: _____
Evening	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩	Where: _____

Sleep: hours slept _____ times woken by pain _____**Medications taken (name, dose, time)**

Appointments, therapy or treatment today

Work: [] worked full day [] partial day: _____ hours missed [] missed whole day [] not working**Things I could not do or needed help with today**

Mood, sleep, stress or other symptoms

Expenses today (medical, mileage, help at home)

Pain level (circle 0-10)

Morning	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩	Where: _____
Afternoon	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩	Where: _____
Evening	①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩	Where: _____

Sleep: hours slept _____ times woken by pain _____**Medications taken (name, dose, time)**

Appointments, therapy or treatment today

Work: [] worked full day [] partial day: _____ hours missed [] missed whole day [] not working**Things I could not do or needed help with today**

Mood, sleep, stress or other symptoms

Expenses today (medical, mileage, help at home)
