Daily Pain Diary

MEDIHERB™

Name: _____

Date: _____

Practitioner Details

Q How did you sleep last night? (Tick)

Trouble falling asleep	Woke once	Woke multiple times	Woke early and couldn't get back to sleep	Slept through

Q How refreshed did you feel when you woke this morning?

1	2	3	4	5	6	7	8	9	10

Exhausted — Very well rested

Q To what extent did pain impact your sleep?

1	2	3	4	5	6	7	8	9	10

Not at all — Significant impact

Q Energy Level (overall throughout the day)

1	2	3	4	5	6	7	8	9	10

No energy — High energy

Q Activity Level (including housework, shopping, work (if physical), exercise etc.)

1	2	3	4	5	6	7	8	9	10

Low activity (e.g. couldn't get out of bed) — Very active

Q If you exercised, what did you do and for how long?

Q Did the exercise exacerbate or relieve your pain?

Exacerbate	Relieve	Neither

Q Stress Level

1	2	3	4	5	6	7	8	9	10

Very relaxed — Extreme stress

Q Where are you in your menstrual cycle (if applicable): Day _____

Q Daily Pain Relief (list all medications/supplements and the dose taken)

e.g. Fish Oil - 4 capsules

Q Daily Food Intake include beverages (alcohol/coffee/water etc.)

Food	Time	Symptoms
Breakfast:		
Morning Tea:		
Lunch:		
Afternoon Tea:		
Dinner:		
Supper:		

Q Number of cigarettes smoked: _____

Q Pain severity overall today

1	2	3	4	5	6	7	8	9	10

No pain Extreme pain

Q Today the pain was: (tick all that apply)

Constant	Intermittent	Throbbing	Stabbing	Burning	Sharp	Crushing	Shooting	Aching	Dull	Cramping

Q Today the pain radiated to: _____

Q Today the pain inhibited my ability to: _____

Q Pain Flares

Time	Location (e.g. leg)	Severity (out of 10)	Suspected Trigger	Rescue: medication/ supplement/intervention
				e.g. heat pack/paracetamol