**NAME :**
**ADDRESS :**
**DOB :**

**MEDICAL CONDITIONS :**

**DOCTOR :**

| Date & Time | Pain scale 0 - 10 | Description & location of pain & other problems (include side effects of meds) | Meds, treatments, non-drug therapies | Activity eg: exercise, walking, lying, sitting, standing, showering, talking, housework | Food & Drink | Extra comments eg: weather, mood, stress, hormones, disturbed sleep. Did meds help? |
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