


PAIN DIARY

Name:	For Doctor:	
Dates from:	To:	Type of pain: __Headache __Abdominal pain __Other
Phone:		

Date									
Warning signs									
Time begun									
Time ended									
Type of pain (throbbing, dull, sharp, piercing)									
Intensity of pain (1 is no pain, 5 is severe pain)	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5	0 1 2 3 4 5
	 0 No Hurt 1 Hurts Little Bit 2 Hurts Little More 3 Hurts Even More 4 Hurts Whole Lot 5 Hurts Worst								
Location									
Treatment or medication taken									
Hours of sleep									
Food/Drink									
Events or stress prior to pain									
Other comments									

You may FAX to El Camino Pediatrics at 760.753.2155 or bring to your next appointment