Name _____

Condition _____ Date of birth _____

PAIN AND SYMPTOM MANAGEMENT LOG

Please print several sheets and record 2-3 entries *EVERY DAY* until your appointment.

DATE	TIME	What are you doing — working, driving, trying to sleep? IF TRACKING PAIN, WHERE DOES IT HURT?	Number your symptom from 1-10 (1=slightest, 10=worst)	What, if anything, do you do or take for symptom control at this time? (You may tell us if you are using marijuana.)	Number your symptom (1-10) 1 hour after treatment