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PAIN / DISCOMFORT - TREATMENT DIARY
Physical Medicine Treatment

Patient Name: _____ Treatment Date: _____

Pain Scale before treatment: _____

Pain Scale after treatment: _____ Time: ____ : _____ am / pm

Please complete this pain / discomfort diary at the intervals stated below and bring this form to your next follow-up office visit with your provider.

Analgesic Duration Hourly Log	Pain / Discomfort Level on a scale of 1 - 10
1 Hr after treatment	
2 Hrs after treatment	
3 Hrs after treatment	
4 Hrs after treatment	
6 Hrs after treatment	
12 Hrs after treatment	
24 Hrs after treatment	