CHRONIC SYMPTOM LOG

NAME: _____ **TODAY'S DATE:** _____

DATE					
TIME OF DAY					
EXACT LOCATION OF PAIN					
INTENSITY 1. No interference/activity 2. Interference w/ activity 3. Cries/doubles over in pain					
TYPE OF PAIN (Burning, cramping, throbbing, sharp, dull, etc.)					
DURATION (Seconds, minutes, hours)					
ASSOCIATED SYMPTOMS (Nausea, dizziness, etc.)					
ASSOCIATED ACTIVITIES What is happening when pain occurs (test, on the phone, etc.)					
WHAT & WHEN was the last food prior to onset of pain					
DOES ANYTHING ALWAYS MAKE THE PAIN BETTER OR WORSE?					
OTHER					