LEAN PAIN RELIEF INITIATIVE

7 Day Pain and Function Journal

A practical tool to help you notice patterns and prepare for conversations with your healthcare professional

Pain is more than a number

Track how pain affects sleep, movement, mood, daily activities, and the goals that matter to you.

Name or initials optional _____
Week beginning _____
Healthcare professional or clinic optional _____

Keep this journal private. Share only the pages you choose with people involved in your care.

GETTING STARTED

How to Use This Journal

Complete one daily page at about the same time each day. Most entries should take about five minutes.

What to Record

- Where the pain is, what it feels like, and how intense it has been.
- How pain affects sleep, movement, mood, and everyday activities.
- What you tried, what helped, and any side effects or concerns.
- One functional goal, such as walking to the mailbox, cooking a meal, or sleeping longer.

Four Simple Steps

1	Complete the pain overview and body map once at the start of the week.
2	Use one daily page each day. Honest estimates are more useful than perfect numbers.
3	Review the week for patterns in activity, sleep, mood, treatments, and pain.
4	Bring the appointment summary to your next healthcare visit if you wish.

Use the scales consistently. On each 0 to 10 scale, 0 means none and 10 means the highest level described. Your score does not need to match anyone else's.

Do not change medication on your own. Record medicines exactly as taken, but do not start, stop, taper, or change a dose without guidance from the prescriber or pharmacist. This includes opioid medication.

Get urgent help when needed. This journal cannot determine whether symptoms are an emergency. Call 911 in the United States or your local emergency number for severe or life-threatening symptoms. Promptly contact a qualified healthcare professional about new or worsening pain or other concerning symptoms.

This educational resource supports communication and self-observation. It does not diagnose a condition, recommend treatment, or create a clinician-patient relationship.

MY STARTING POINT

Pain Overview

Complete this page once. Use your own words and leave any item blank if it does not apply.

Pain began _____	**Pattern** _____

- ☐ Sudden
- ☐ Gradual
- ☐ Comes and goes
- ☐ Constant
- ☐ Changing
- ☐ Unsure

Main pain location or areas *Example: lower back and left leg*

How the pain feels *Example: aching, burning, pressure, sharp, tingling*

- ☐ Aching
- ☐ Burning
- ☐ Cramping
- ☐ Electric
- ☐ Numb
- ☐ Pressure
- ☐ Sharp
- ☐ Sore
- ☐ Stabbing
- ☐ Throbbing
- ☐ Tingling
- ☐ Other

What tends to make it worse

What tends to make it better

Diagnosis or explanation I have been given if known

Allergies or medication sensitivities I want my care team to know

MY CURRENT APPROACH

Goals and Pain Care Plan

Record your current plan. This page is for communication and does not replace your medication list or clinician instructions.

Goals That Matter to Me

One activity I want pain to interfere with less *Be specific and realistic*

How I will know I am making progress *Example: stand for 10 minutes or wake once instead of three times*

Medicines I Currently Use for Pain

Medicine	Dose	When I take it	Benefit or concern

Include prescription and nonprescription products. Keep your official medication list current.

Other Strategies I Currently Use

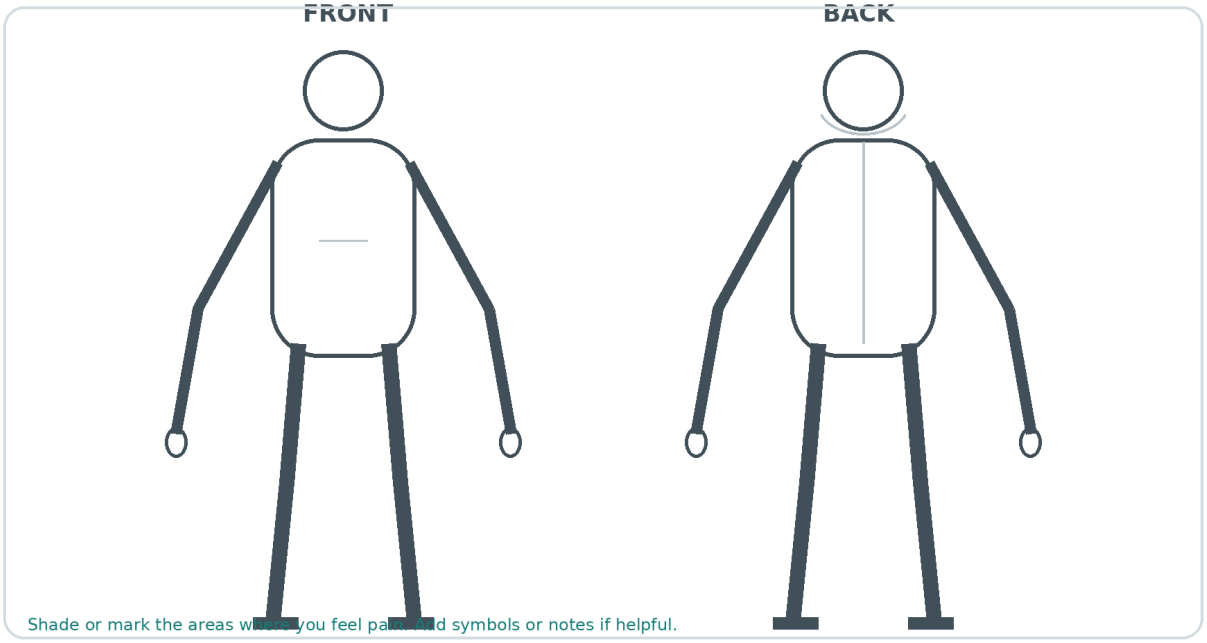
- ☐ Movement or exercise
- ☐ Physical or occupational therapy
- ☐ Heat
- ☐ Cold
- ☐ Stretching
- ☐ Pacing and planned rest
- ☐ Relaxation or breathing
- ☐ Mindfulness
- ☐ Music or distraction
- ☐ Massage
- ☐ Counseling or support
- ☐ Other

Instructions or precautions from my healthcare professional

WHERE I FEEL PAIN

Pain Body Map

Shade the painful areas. Use different marks for different feelings, and add arrows if pain travels.



Mark	Meaning
X	Main pain
///	Aching or soreness
***	Burning or tingling
→	Pain travels

Notes about location or movement of pain

DAY 1

Daily Pain and Function Entry

Complete this page once today. Circle numbers and check only the items that apply.

Date _____	**Time completed** _____
Hours slept last night _____	**Sleep quality 0 to 10** _____

Pain Snapshot

Pain location today	_____
Pain scores	Now ____ Lowest ____ Highest ____ 0 No pain to 10 Worst pain

☐ Aching ☐ Burning ☐ Cramping ☐ Electric
☐ Numb ☐ Pressure ☐ Sharp ☐ Sore
☐ Stabbing ☐ Throbbing ☐ Tingling ☐ Other

Impact Today

Pain interference	Circle one 0 None to 10 Complete interference
Daily activity	0 1 2 3 4 5 6 7 8 9 10
Mood	0 1 2 3 4 5 6 7 8 9 10
Sleep or rest	0 1 2 3 4 5 6 7 8 9 10

What I Tried

☐ Medication as directed ☐ Movement or therapy ☐ Heat or cold
☐ Stretching ☐ Pacing or rest ☐ Relaxation or breathing
☐ Music or distraction ☐ Support or counseling ☐ Other

Overall benefit	0 1 2 3 4 5 6 7 8 9 10
Relief lasted	_____
Side effects or concerns	_____

My Function Goal

Activity I wanted to do	_____
What I was able to do	_____
One note or question	_____

DAY 2

Daily Pain and Function Entry

Complete this page once today. Circle numbers and check only the items that apply.

Date _____	Time completed _____

Hours slept last night _____	Sleep quality 0 to 10 _____

Pain Snapshot

Pain location today	_____
Pain scores	Now ____ Lowest ____ Highest ____ 0 No pain to 10 Worst pain

☐ Aching ☐ Burning ☐ Cramping ☐ Electric
☐ Numb ☐ Pressure ☐ Sharp ☐ Sore
☐ Stabbing ☐ Throbbing ☐ Tingling ☐ Other

Impact Today

Pain interference	Circle one 0 None to 10 Complete interference
Daily activity	0 1 2 3 4 5 6 7 8 9 10
Mood	0 1 2 3 4 5 6 7 8 9 10
Sleep or rest	0 1 2 3 4 5 6 7 8 9 10

What I Tried

☐ Medication as directed ☐ Movement or therapy ☐ Heat or cold
☐ Stretching ☐ Pacing or rest ☐ Relaxation or breathing
☐ Music or distraction ☐ Support or counseling ☐ Other

Overall benefit	0 1 2 3 4 5 6 7 8 9 10
Relief lasted	_____
Side effects or concerns	_____

My Function Goal

Activity I wanted to do	_____
What I was able to do	_____
One note or question	_____

DAY 3

Daily Pain and Function Entry

Complete this page once today. Circle numbers and check only the items that apply.

Date _____	Time completed _____

Hours slept last night _____	Sleep quality 0 to 10 _____

Pain Snapshot

Pain location today	_____
Pain scores	Now ____ Lowest ____ Highest ____ 0 No pain to 10 Worst pain

☐ Aching ☐ Burning ☐ Cramping ☐ Electric
☐ Numb ☐ Pressure ☐ Sharp ☐ Sore
☐ Stabbing ☐ Throbbing ☐ Tingling ☐ Other

Impact Today

Pain interference	Circle one 0 None to 10 Complete interference
Daily activity	0 1 2 3 4 5 6 7 8 9 10
Mood	0 1 2 3 4 5 6 7 8 9 10
Sleep or rest	0 1 2 3 4 5 6 7 8 9 10

What I Tried

☐ Medication as directed ☐ Movement or therapy ☐ Heat or cold
☐ Stretching ☐ Pacing or rest ☐ Relaxation or breathing
☐ Music or distraction ☐ Support or counseling ☐ Other

Overall benefit	0 1 2 3 4 5 6 7 8 9 10
Relief lasted	_____
Side effects or concerns	_____

My Function Goal

Activity I wanted to do	_____
What I was able to do	_____
One note or question	_____

DAY 4

Daily Pain and Function Entry

Complete this page once today. Circle numbers and check only the items that apply.

Date _____	**Time completed** _____

Hours slept last night _____	**Sleep quality 0 to 10** _____

Pain Snapshot

Pain location today	_____
Pain scores	Now ____ Lowest ____ Highest ____ 0 No pain to 10 Worst pain

☐ Aching ☐ Burning ☐ Cramping ☐ Electric
☐ Numb ☐ Pressure ☐ Sharp ☐ Sore
☐ Stabbing ☐ Throbbing ☐ Tingling ☐ Other

Impact Today

Pain interference	Circle one 0 None to 10 Complete interference
Daily activity	0 1 2 3 4 5 6 7 8 9 10
Mood	0 1 2 3 4 5 6 7 8 9 10
Sleep or rest	0 1 2 3 4 5 6 7 8 9 10

What I Tried

☐ Medication as directed ☐ Movement or therapy ☐ Heat or cold
☐ Stretching ☐ Pacing or rest ☐ Relaxation or breathing
☐ Music or distraction ☐ Support or counseling ☐ Other

Overall benefit	0 1 2 3 4 5 6 7 8 9 10
Relief lasted	_____
Side effects or concerns	_____

My Function Goal

Activity I wanted to do	_____
What I was able to do	_____
One note or question	_____

DAY 5

Daily Pain and Function Entry

Complete this page once today. Circle numbers and check only the items that apply.

Date _____	Time completed _____

Hours slept last night _____	Sleep quality 0 to 10 _____

Pain Snapshot

Pain location today	_____
Pain scores	Now ____ Lowest ____ Highest ____ 0 No pain to 10 Worst pain

☐ Aching ☐ Burning ☐ Cramping ☐ Electric
☐ Numb ☐ Pressure ☐ Sharp ☐ Sore
☐ Stabbing ☐ Throbbing ☐ Tingling ☐ Other

Impact Today

Pain interference	Circle one 0 None to 10 Complete interference
Daily activity	0 1 2 3 4 5 6 7 8 9 10
Mood	0 1 2 3 4 5 6 7 8 9 10
Sleep or rest	0 1 2 3 4 5 6 7 8 9 10

What I Tried

☐ Medication as directed ☐ Movement or therapy ☐ Heat or cold
☐ Stretching ☐ Pacing or rest ☐ Relaxation or breathing
☐ Music or distraction ☐ Support or counseling ☐ Other

Overall benefit	0 1 2 3 4 5 6 7 8 9 10
Relief lasted	_____
Side effects or concerns	_____

My Function Goal

Activity I wanted to do	_____
What I was able to do	_____
One note or question	_____

DAY 6

Daily Pain and Function Entry

Complete this page once today. Circle numbers and check only the items that apply.

Date _____	**Time completed** _____

Hours slept last night _____	**Sleep quality 0 to 10** _____

Pain Snapshot

Pain location today	_____
Pain scores	Now ____ Lowest ____ Highest ____ 0 No pain to 10 Worst pain

☐ Aching ☐ Burning ☐ Cramping ☐ Electric
☐ Numb ☐ Pressure ☐ Sharp ☐ Sore
☐ Stabbing ☐ Throbbing ☐ Tingling ☐ Other

Impact Today

Pain interference	Circle one 0 None to 10 Complete interference
Daily activity	0 1 2 3 4 5 6 7 8 9 10
Mood	0 1 2 3 4 5 6 7 8 9 10
Sleep or rest	0 1 2 3 4 5 6 7 8 9 10

What I Tried

☐ Medication as directed ☐ Movement or therapy ☐ Heat or cold
☐ Stretching ☐ Pacing or rest ☐ Relaxation or breathing
☐ Music or distraction ☐ Support or counseling ☐ Other

Overall benefit	0 1 2 3 4 5 6 7 8 9 10
Relief lasted	_____
Side effects or concerns	_____

My Function Goal

Activity I wanted to do	_____
What I was able to do	_____
One note or question	_____

DAY 7

Daily Pain and Function Entry

Complete this page once today. Circle numbers and check only the items that apply.

Date _____	Time completed _____

Hours slept last night _____	Sleep quality 0 to 10 _____

Pain Snapshot

Pain location today	_____
Pain scores	Now ____ Lowest ____ Highest ____ 0 No pain to 10 Worst pain

☐ Aching ☐ Burning ☐ Cramping ☐ Electric
☐ Numb ☐ Pressure ☐ Sharp ☐ Sore
☐ Stabbing ☐ Throbbing ☐ Tingling ☐ Other

Impact Today

Pain interference	Circle one 0 None to 10 Complete interference
Daily activity	0 1 2 3 4 5 6 7 8 9 10
Mood	0 1 2 3 4 5 6 7 8 9 10
Sleep or rest	0 1 2 3 4 5 6 7 8 9 10

What I Tried

☐ Medication as directed ☐ Movement or therapy ☐ Heat or cold
☐ Stretching ☐ Pacing or rest ☐ Relaxation or breathing
☐ Music or distraction ☐ Support or counseling ☐ Other

Overall benefit	0 1 2 3 4 5 6 7 8 9 10
Relief lasted	_____
Side effects or concerns	_____

My Function Goal

Activity I wanted to do	_____
What I was able to do	_____
One note or question	_____

END OF WEEK REVIEW

Patterns I Noticed

Look across the seven daily pages. Focus on patterns and function, not on finding a perfect score.

The day or time my pain was most manageable

The day or time my pain was hardest to manage

Activities situations or triggers that seemed connected to more pain

Strategies that seemed most helpful

Patterns I noticed in sleep mood movement or stress

Progress Toward My Goal

- ☐ Improved
- ☐ Stayed about the same
- ☐ Was harder this week
- ☐ Not enough information yet

What changed in the activity that matters to me

What I want to continue discuss or reconsider with my healthcare professional

VISIT PREPARATION

Appointment Summary

Complete this page before a visit. Bring only the pages you are comfortable sharing.

My most important goal for this visit

What has changed since my last visit *Pain location, intensity, function, sleep, mood, or new symptoms*

What has helped most

What has not helped or has caused problems

Medication questions side effects or refill concerns

My Questions

1	
2	
3	

Plan From the Visit

Next steps instructions and follow up

USE WHEN NEEDED

Pain Flare Record

Use this page for a noticeable increase or change in pain. Contact a healthcare professional when symptoms concern you.

Date and time flare began	Sudden or gradual
_____	_____

What I was doing before it began

Location and description of the pain

Highest pain during the flare

0	1	2	3	4	5	6	7	8	9	10

0 No pain *Circle one* *10 Worst pain you can imagine*

Other symptoms or changes I noticed

What I tried and when

What happened afterward *Benefit, side effect, function, or change in symptoms*

Healthcare professional contacted	Date and time
_____	_____

Instructions I received

FOR SAFE USE

Sources and Important Information

This journal uses a person-centered approach that considers pain, function, sleep, mood, treatment response, and individual goals.

Medical Disclaimer

The Lean Pain Relief Initiative provides educational information and practical tools. It is not a clinic or medical practice. This journal does not provide a diagnosis, prescribe treatment, replace professional medical advice, or create a clinician-patient relationship. A qualified healthcare professional should interpret your symptoms and help you make treatment decisions based on your individual circumstances.

Do not use this journal to start, stop, taper, or change medication. Seek immediate help for a medical emergency. Warning signs vary, and this journal cannot list or evaluate every urgent situation.

Privacy

This journal may contain sensitive health information. Store it securely. If you share it electronically, use a method recommended by your healthcare organization. You may use initials instead of your full name and share only the pages relevant to your care.

Patient Education Sources

Centers for Disease Control and Prevention. Working Together With Your Doctor to Manage Your Pain. Read the CDC patient guidance

Centers for Disease Control and Prevention. Opioid Therapy and Different Types of Pain. Read the CDC pain overview

Centers for Disease Control and Prevention. Clinical Practice Guideline for Prescribing Opioids for Pain, United States, 2022. Read the guideline

These sources support shared decision-making, individualized care, attention to function and quality of life, and discussion of the benefits and risks of pain treatments. The journal is an original educational tool and is not a validated clinical assessment instrument.

Notes

Additional notes or questions