Pain Diary

for Autosomal Dominant Polycystic Kidney Disease (ADPKD)

BCRenal
Provincial Health Services Authority

▶ Often, doctors ask patients to describe their pain using a scale from 1 to 10, where 0 is no pain and 10 is extreme pain. This scale also describes how pain is impacting your quality of life and/or ability to complete daily activities. You can use the infographic included in this pain diary to determine how to rate your pain.

Pain Intensity	0 No pain	1-2 Mild Pain		3-5 Moderate Pain			6-7 Severe Pain		8-9 Very Severe Pain		10 Worst Pain Possible
Impact on Quality of Life (QoL)	**Normal Quality of Life**										**Non-Functioning**
	• Work/ volunteer, normal activities each day • Social life outside of work • Take an active part in family life	• Work/ volunteer, be active 8 hours daily • Outside social activities limited • Take part in family life	• Work/ volunteer, at least 6 hours daily • Have energy to make plans for 1 social activity weekly • Active on weekends	• Work/ volunteer, a few hours daily • Active at least 5 hours a day • Do simple activities on the weekend	• Work/ volunteer, limited hours • Take part in limited social activities on weekends	• Work/ volunteer, minimal hours possible • Do simple chores around house • Minimal activities outside of home 2 days a week	• Not able to work/ volunteer • Struggle but fulfill daily home responsi-bilities • No outside activity	• Get dressed in morning • Minimal activities at home • Contact with friends via phone, email	• Get out of bed but don't get dressed • Stay at home all day	• Stay in bed at least half the day • Have no contact with out-side world	• Stay in bed all day • Feel hope-less and helpless about life

Link to references

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Date & Time	**Rate pain and impact on quality of life (0-10)** *see image and descriptions on pg 1	**Describe pain** (e.g. where is it? how does it feel? how long did it last?)	**What triggered the pain?**	**How did you treat it? What non-medication strategies did you try?** (e.g. rest, exercise, stretching)		**How did you feel after treating it? What worked? What didn't work?**
				Non-Medications	**Medications (if required)**	

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				Non-Medications	Medications (if required)	

Date & Time	Comments, Notes or Questions

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