Frankston Pain Management

Interventional and Interdisciplinary Pain Management

7/20 Clarendon St,
Frankston, Vic, 3199
Tel: 03 9770 0522

Email: info@fpmx.com.au
Web site: www.fpmx.com.au
Fax: 03 9770 0944

Dear Patient,

Thank you for answering the questions on the attached forms and completing the series of questionnaires, registration form. **Please use a black or red pen** to answer the questions. (please do not use a pencil as it does not scan well.) We use this information to see how your pain affects your life, to plan and monitor your treatment.

Suffering from severe pain for a long time frequently makes things difficult for you and your family. These questionnaires are not designed to “trick you” or see if the pain is “in your head”, rather, the questionnaires show us how the pain has affected your activity, mood, enjoyment of life and lifestyle.

The different forms tell us about the onset, timing and impact of your pain.

- The Patient Information and Pain History questionnaires tells us about you, your pain, general health, previous treatments and current medication usage.
- The PainDetect Questionnaire has a body diagram for you to show us where you have pain and questions about intensity and character of your pain.
- The DASS questionnaires are used to see how the pain affects your mood.
- The SF-36 questionnaire is used to provide more information on your overall health status and how your pain interferes with your daily life.
- The Activity Diary is for you to show us what happens in your life over two days. Instructions for this diary are on the other side of the diary.

Please read and follow the instructions on each form. Please feel free to contact the rooms at any time if you have any queries.

If you have difficulty completing the forms, please ask your general practitioner or a trusted friend for assistance. For $30, a clinic nurse can also help you complete the forms.

Please note that you must return **ALL** forms, the referral and questionnaires (except activity diary) **before** we give you an appointment. Please return the forms by email to info@fpmx.com.au, fax to 03 9770 0944 or post/hand to 7/20 Clarendon Street, Frankston 3199. Please keep the 2-day activity diary and give it to the nurse or doctor at your visit

Kind regards,

Dr Murray Taverner,

Pain Medicine Specialist

NEW PATIENT QUESTIONNAIRE

Did you need help filling out this questionnaire?

☐ No help needed ☐ Family member ☐ Friend ☐ Health care Professional Today's Date:........../ ..../...........

1. SURNAME:...
2. Other names: ....
3. Date of birth: ....
4. Sex: ☐ Male ☐ Female
5. Country of birth ....
6. If other than Australia, what year did you arrive: ....

7. What is your current **marital status**? (please tick one):
   1 ☐ Married 2 ☐ DeFacto 3 ☐ Divorced 4 ☐ Separated 5 ☐ Single 6 ☐ Widowed

8. Do you live (tick ONE):
   1 ☐ Alone 2 ☐ With husband/wife and children 3 ☐ With child/children only
   4 ☐ With parents or other relatives 5 ☐ With husband/wife/partner 6 ☐ With friends/flatmates

9. What is your **highest level of education**? (Please tick one)
   1 ☐ Less than 3 yrs secondary school 2 ☐ School Cert/Intermediate 3 ☐ HSC / Leaving Cert.
   4 ☐ TAFE/ Technical college 5 ☐ University / CAE 6 ☐ Other (specify)...................................

10. What was your **main occupation** before your pain/injury?...
    How many hours per week were you working before your pain/injury?...

11. Work Status: Are you
    1 ☐ Working
    A ☐ Normal Duties B ☐ Modified Duties
    C ☐ Normal Hours D ☐ Modified hours - How many hours per week: ....
    E ☐ How many days sick leave used? last month: .... last year:...
    2 ☐ Not working from pain or injury: Date last worked: ....
    3 ☐ Not working for other reasons: ☐ Voluntary work ☐ home duties ☐ retired ☐ student ☐ retraining
    ☐ Other...

12. How did your pain begin? (**tick** ONE; if more than one applies, tick the one which **applies BEST**)
    1 ☐ Accident at work 4 ☐ Car accident 7 ☐ After an illness
    2 ☐ At work, but not involving accident 5 ☐ Sporting accident 8 ☐ Pain just began, no clear reason
    3 ☐ Accident at home 6 ☐ After surgery 9 ☐ Other reasons (describe)...............................

13. Is this visit related to a compensation claim?
    1 ☐ Worker's Compensation claim? 2 ☐ Motor Accident Compensation claim?
    3 ☐ Some other legal case? 4 ☐ None of the above

14. Has your claim been settled? ☐ Yes ☐ No If yes, date settled:...

15. What is your **current source of income**? (Please tick. You may tick more than one)
    1 ☐ Worker's Compensation insurance 2 ☐ Sickness Benefits 3 ☐ Age pension
    4 ☐ Disability/Invalid pension 5 ☐ Partner's/wife's/husband's earning 6 ☐ Wages / salary
    7 ☐ Self Employed 8 ☐ Unemployment/Job Search benefits 9 ☐ Supporting parents benefits
    10 ☐ Superannuation payments 11 ☐ Savings/investment 12 ☐ Austudy
    13 ☐ TAC 14 ☐ Other (specify)...

PAIN HISTORY

Name: .... Today's Date: ..../ ..... /.....

1. When did your pain first start? Please be exact as possible

   DAY .... MONTH .... YEAR ....

2. If your pain comes and goes, when did the **present episode** of pain start? (Answer this only if different from Quest. 1)

   DAY .... MONTH .... YEAR ....

3. How many tablets do you take for pain each day? ....
4. How many tablets do you take for reasons other than pain each day?
5. Pain Sites: (please **Rate** each of your pain(s) using a 0-10 scale, with 0 no pain and 10 being worst imaginable pain) Leave the space blank if you do not have pain in that area.

Site	Left	Right	Site	Left	Right	Site	Left	Right
Head - front			Elbow			Buttock		
Head - back			Forearm			Hip		
Face			Wrist/Hand			Thigh		
Neck			Chest			Knee		
Shoulder			Abdomen			Lower leg (calf etc)		
Upper Back			Midback			Ankle/foot		
Upper Arm			Low Back			Groin		

Please **Rank** the 5 worst pains

1. ....
2. ....
3. ....
4. ....
5. ....

6. Location of **Main** Pain: ☐ Dominant Side ☐ Non-Dominant side ☐ Both sides

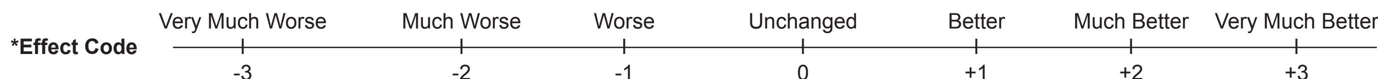
7. **Which statement best describes your main pain**?

1 ☐ Single episode, limited duration
2 ☐ Continuous or nearly continuous, same intensity
3 ☐ Continuous or nearly continuous, variable intensity
4 ☐ Recurring irregularly
5 ☐ Recurring regularly
6 ☐ Paroxysmal (short attacks)
7 ☐ Sustained with superimposed paroxysms
8 ☐ Other combinations ....
9 ☐ None of these ....
10 ☐ Not applicable

8. Who of the following have you seen about your pain: Since it started? In the last 3 months? How effective/helpful?

	Visits Since Start	Visits Last 3 months	Effect*		Visits Since Start	Visits Last 3 months	Effect*		Visits Since Start	Visits Last 3 months	Effect*
☐ Acupuncturist				☐ Neurologist				☐ Psychologist			
☐ Anaesthetist				☐ Neurosurgeon				☐ Rehab Physician			
☐ Chiropractor				☐ Occ. Therapist				☐ Rheumatologist			
☐ General Practitioner				☐ Ortho. Surgeon				☐ Sports Med. Doctor			
☐ AH GP/Locum calls				☐ Pain Clinic				☐ Massage & others			
☐ Naturo/Homeopath				☐ Physiotherapist				☐ Medicolegal Exams			
☐ Hydrotherapist				☐ Psychiatrist				☐ Accident & Emergency			
☐ Hypnotherapist				☐ Exercise Therapist				☐ Days in Hospital =			

***Effect Code**



9. Task Performance - Please list 4 goals/tasks/things that your pain prevents/limits, that you want to do?

Does the main problem limit any of your activities? ☐ ***YES*** ☐ ***NO***

Please list the 4 activities and indicate how much they are limited by your pain	CANNOT DO AT ALL	CAN DO BUT SEVERELY LIMITED	CAN DO BUT MODERATELY LIMITED	CAN DO BUT SLIGHTLY LIMITED	CAN DO WITHOUT LIMITATION
1.					
2.					
3.					
4.					

HEALTH SURVEY

Name: ....Today's Date: .... / ....../ ......

Tick if you have you ever had any of the following:

- ☐ High blood pressure
- ☐ Blood clots in the legs/lungs
- ☐ Angina
- ☐ Heart Attack
- ☐ Congestive Heart Failure
- ☐ Irregular heart beat (AF)
- ☐ Stroke or mini-stroke
- ☐ Pacemaker/defibrillator
- ☐ Breathlessness: Rest/Walk
- ☐ Diabetes: Insulin, Oral, Diet
- ☐ Asthma
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Chronic Lung Disease
- ☐ Sleep Apnoea
- ☐ Mental, Emotional disorder
- ☐ Alzheimer's or dementia
- ☐ Fall in last 6 months
- ☐ Arthritis
- ☐ Migraines
- ☐ Epilepsy
- ☐ Hiatus Hernia/Reflux
- ☐ Stomach Ulcer
- ☐ Bowel Bleeding
- ☐ Recurrent Diarrhoea
- ☐ Chronic Constipation
- ☐ Kidney Disease
- ☐ Trouble passing urine
- ☐ Cancer or Chemotherapy
- ☐ Fevers
- ☐ Night Sweats
- ☐ Unexpected weight loss
- ☐ Reaction to IV contrast
- ☐ Hepatitis ☐ A ☐ B ☐ C
- ☐ AIDS risk
- ☐ Steriods (cortisone)
- ☐ Bleeding Tendancy
- ☐ Anticoagulants
- ☐ Anaemia
- ☐ Blood Transfusion
- ☐ Transfusion reaction
- ☐ Eczema
- ☐ Latex Allergy
- ☐ Anaesthetic problem

How tall are you?................ How much do you weigh?.................... What is your waist circumference (cm)? ....

Any other Medical History:...

....

SURGICAL HISTORY

______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

______________________ ______________________

PAST PAIN TREATMENTS QUESTIONNAIRE

WHAT WAS DONE?	WHEN (approx)	WHO DID IT?	HOW SUCCESSFUL (describe using the effect code below)
*Effect Code: very much worse -3 · much worse -2 · worse -1 · unchanged 0 · better +1 · much better +2 · very much better +3			

ATTACH ANOTHER PAGE IF MORE SPACE NEEDED

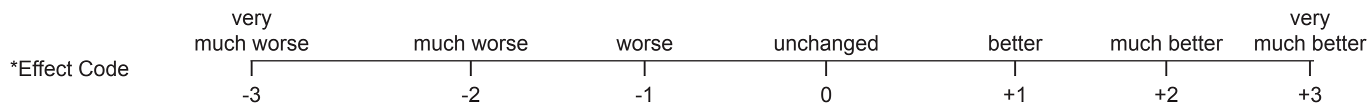
Name:..Today's Date:......./....../ ......

PAST DRUGS

DRUG	Dose & Frequency	Duration	* Effect Code	Effects and Side Effects Description	Why Ceased

CURRENT DRUGS

DRUG	Dose & Frequency	Duration	* Effect Code	Effects and Side Effects Description



ALLERGIES: ....

....

CAGE - AID (please tick Yes or No)

☐ Yes ☐ No Have you ever felt you should **C**ut down your use of alcohol or drugs?

☐ Yes ☐ No Have you ever been **A**nnoyed when people have commented on your use?

☐ Yes ☐ No Have you ever felt **G**uilty or badly about your use?

☐ Yes ☐ No Have you ever used alcohol or drugs to **E**ase withdrawal symptoms, or to avoid feeling low after using?

Alcohol: ☐ No ☐ Yes How much? ☐ <2 ☐ 3-6 ☐ 7+ How often? ☐ Daily ☐ Weekly ☐ Monthly or less

Smoker: ☐ Never ☐ Ex-smoker, age you quit............ ☐ Smoker Age started:.......... how many per day....................

Other Drugs: ☐ Never ☐ Quit, age you quit™........... Age started........... How often? ☐ Daily ☐ Weekly ☐ Monthly or less

Name: ....Today's Date: .... / ..../ ......

Your Story

Instructions: Please fill in the sections below following a logical date or sequence order.
Please be as brief and accurate as possible as this saves time (and money) during the consultation.
Please use more paper or copy the headings on to your own paper if needed.

1. Your Story: Describe the sequence of events from the onset of your problem/pain until now

2. Describe Your Pain(s): Describe up to 3 pains using the following headings

How did your pain start; what words best describe pains; pain location(s); pain intensity (0-10/10 no pain - worst imaginable pain scale); what makes the pain better or worse; what treatments have you tried and how well did/do they work? Attach extra page if needed.

3. Describe the Impact of Pain on:

Personal Care, Domestic, Community, Work (paid/unpaid), Social activities and emotions

FPM Extra Questions

Patient details

Name: ....

DOB: ....

Attach Label

Major life events may affect your answers to this questionnaire. Please indicate whether you have experienced any of the events listed below (or similar events)

Please tick any of the following life events you have experienced? Please also circle if in last 12 month

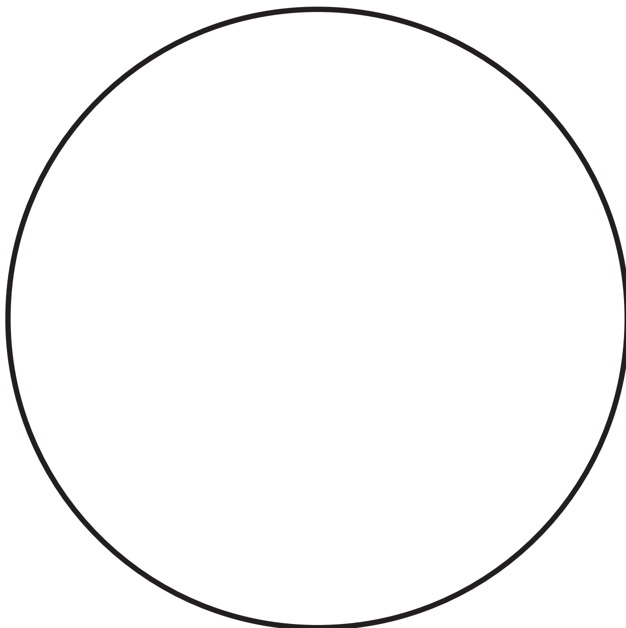
☐ Death of a spouse	Date:..................	☐ Divorce or marital separation	Date:	☐ Loss of employment	Date:.................
☐ Death of a close family member	Date:..................	☐ Problems with children	Date:	☐ Financial difficulties	Date:.................
☐ Personal illness or injury	Date:..................	☐ Road traffic accident	Date:	☐ Retirement	Date:.................
☐ Change of address	Date:..................	☐ Accident at Work	Date:	☐ Jail term	Date:.................
☐ In-Law problems	Date:..................	☐ Work / School problems	Date:	☐ Minor violation of the law	Date:.................
☐ Family problems	Date:..................	☐ Illness of a close family member	Date:	☐ Hospital admission/s	Date:.................
☐ Marital problems	Date:..................	☐ Pregnancy / Birth	Date:		

What makes the pain worse? (you may tick more than one)

☐ Sitting	☐ Household chores	☐ Cold weather	☐ Cycling
☐ Standing	☐ Everything	☐ Hot weather	☐ Sex
☐ Lying down	☐ Loud noise	☐ Weather changes	☐ Stress
☐ Lifting	☐ Working	☐ Walking	☐ Tension
☐ Bending	☐ Any movement	☐ Swimming	☐ Driving
☐ Nothing	☐ Not moving		☐ Stairs and inclines
☐ Other:.................................			

What makes the pain better? (you may tick more than one)

☐ Sitting	☐ Exercise	☐ Cold weather	☐ Sex
☐ Standing	☐ Working	☐ Hot weather	☐ Alcohol
☐ Lying down	☐ Warm/Hot bath	☐ Pressure	☐ Rest
☐ Stretching	☐ Warm/Hot shower	☐ Massage / rubbing	☐ Being with other people
☐ Relaxing	☐ Tablets	☐ Walking	☐ Pacing
☐ Reading	☐ Hot/Cold packs	☐ Cycling	☐ Keeping busy
☐ Watching TV	☐ TENS	☐ Swimming	☐ Nothing
☐ Other:.................................			



Clock Drawing Test

1. Please write/draw numbers inside the circle to make it look like the face of a clock.
2. Then draw the hands of the clock to read “10 past 11”.

Office use:

PAIN DETECT

Name:..Today's Date:....... / ....../ ......

How would you assess your pain - now, at this moment? Circle one number

0 none	1	2	3	4	5	6	7	8	9	10 max

How strong was the strongest pain during the past 4 weeks? Circle one number

0 none	1	2	3	4	5	6	7	8	9	10 max

How strong was the pain on average during the past 4 weeks? Circle one number

0 none	1	2	3	4	5	6	7	8	9	10 max

Mark the picture that best describes the course of your pain

Persistent pain with Slight fluctuations ☐

Persistent pain with pain attacks ☐

Pain attacks without pain between them ☐

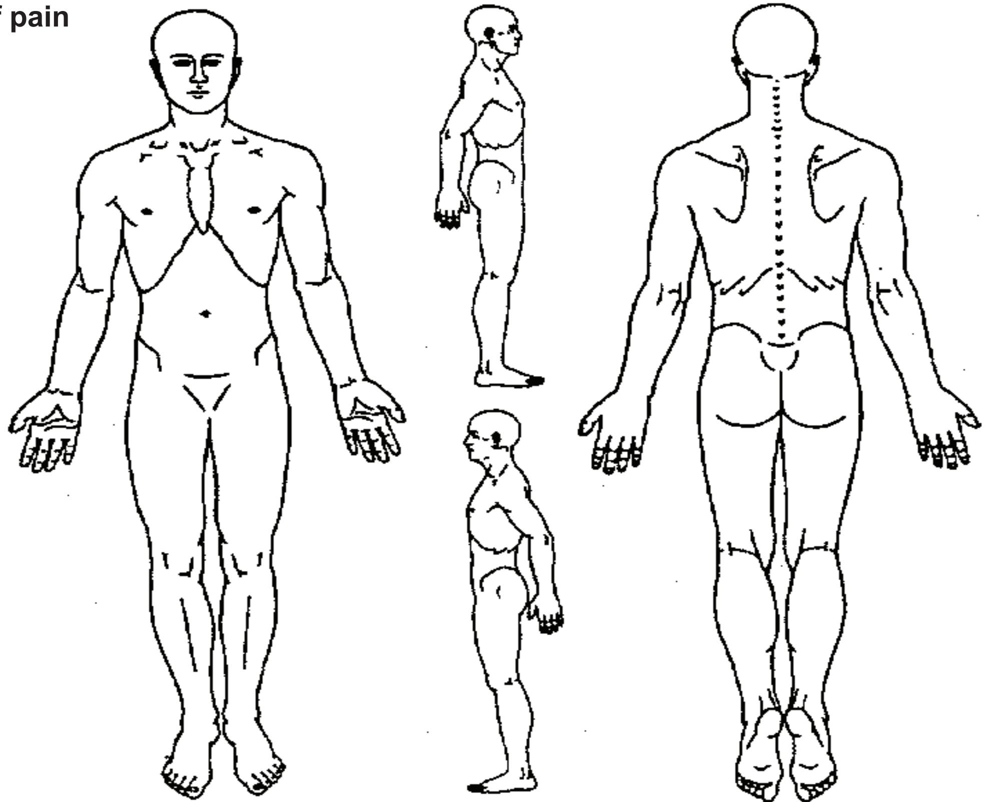
Pain attacks with pain between them ☐

Please mark your main area of pain

Does your pain radiate to other regions of your body?

☐ Yes ☐ No

If yes, please draw the direction in which the pain radiates.



	Never	Hardly noticed	Slightly	Moder-ately	Strongly	Very strongly
Do you suffer from a burning sensation (eg stinging nettles) in the marked areas?						
Do you have a tingling or prickling sensation in the area of your pain (like crawling ants or electrical tingling)						
Is light touching (clothing, a blanket) in this area painful?						
Do you have sudden pain attacks in the area of your pain, like electric shocks						
Is cold or heat (bath water) in this area occasionally painful?						
Do you suffer from a sensation of numbness in the areas that you marked?						
Does slight pressure in this area, eg. with a finger, trigger pain?						
Scoring: *OFFICE USE ONLY*	☐ x 0 = ☐	☐ x 1 = ☐	☐ x 2 = ☐	☐ x 3 = ☐	☐ x 4 = ☐	☐ x 5 = ☐
TOTAL SCORE ☐ **OUT OF 35**						

DASS21

Name: *Date:*

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you *over the past week*. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

0 Did not apply to me at all
1 Applied to me to some degree, or some of the time
2 Applied to me to a considerable degree, or a good part of time
3 Applied to me very much, or most of the time

1	I found it hard to wind down	0	1	2	3
2	I was aware of dryness of my mouth	0	1	2	3
3	I couldn't seem to experience any positive feeling at all	0	1	2	3
4	I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5	I found it difficult to work up the initiative to do things	0	1	2	3
6	I tended to over-react to situations	0	1	2	3
7	I experienced trembling (eg, in the hands)	0	1	2	3
8	I felt that I was using a lot of nervous energy	0	1	2	3
9	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
10	I felt that I had nothing to look forward to	0	1	2	3
11	I found myself getting agitated	0	1	2	3
12	I found it difficult to relax	0	1	2	3
13	I felt down-hearted and blue	0	1	2	3
14	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
15	I felt I was close to panic	0	1	2	3
16	I was unable to become enthusiastic about anything	0	1	2	3
17	I felt I wasn't worth much as a person	0	1	2	3
18	I felt that I was rather touchy	0	1	2	3
19	I was aware of the action of my heart in the absence of physical exertion (eg, sense of heart rate increase, heart missing a beat)	0	1	2	3
20	I felt scared without any good reason	0	1	2	3
21	I felt that life was meaningless	0	1	2	3

SF-36

Patient Name:..Date:..

Instructions: To be completed by the patient. This questionnaire asks for your views about your health, how you feel and how well you are able to do your usual activities. Answer every question by marking the answer as indicated. If you are unsure about how to answer a questions, please give the best answer you can.

1. In general, would you say your health is: *(circle one)*

Excellent	1
Very good	2
Good	3
Fair	4
Poor	5

2. Compared to one year ago, how would you rate your health in general now? (circle one)

Much better now than one year ago	1
Somewhat better now than one year ago	2
About the same as one year ago	3
Somewhat worse now than one year ago	4
Much worse now than one year ago	5

3. The following questions are about activities you might do during a typical day. Does **your health now limit you** in these activities? If so, how much? *(circle one number on each line)*

Activities	Yes, limited a lot	Yes, limited a little	No, not limited at all
a. Vigorous activities, such as running, lifting heavy objects, participating in strenuous sport	1	2	3
b. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling or playing golf	1	2	3
c. Lifting or carrying groceries	1	2	3
d. Climbing several flights of stairs	1	2	3
e. Climbing one flight of stairs	1	2	3
f. Bending, kneeling or stooping	1	2	3
g. Walking **more than one** kilometre	1	2	3
h. Walking half a kilometre	1	2	3
i. Walking **100** metres	1	2	3
j. Bathing and dressing yourself	1	2	3

4. During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of your physical health**? *(circle one number on each line)*

	Yes	No
a. **Cut** down on the **amount of time** you spent on work or other activities	1	2
b. **Accomplished less** than you would like	1	2
c. Were limited in the **kind** of work or other activities	1	2
d. Had **difficulty** performing the work or other activities (for example, it took extra effort)	1	2

5. During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)? *(circle one number on each line)*

	Yes	No
a. **Cut** down on the **amount of time** you spent on work or other activities	1	2
b. **Accomplished less** than you would like	1	2
c. Didn't do work or other activities as **carefully** as usual	1	2

Name: ....Today's Date: .... / ....../ ......

6. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbours or groups? *(circle one)*

Not at all	1
Slightly	2
Moderately	3
Quite a bit	4
Extremely	5

7. How much bodily pain have you had during the past 4 weeks? *(circle one)*

No bodily pain	1
Very mild	2
Mild	3
Moderate	4
Severe	5
Very Severe	6

8. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)? (circle one)

Not at all	1
A little bit	2
Moderately	3
Quite a bit	4
Extremely	5

9. These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

How much time during the past 4 weeks -	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
a. Did you feel full of life	1	2	3	4	5	6
b. Have you been a very nervous person?	1	2	3	4	5	6
c. Have you felt so down in the dumps that nothing could cheer you up?	1	2	3	4	5	6
d. Have you felt calm and peaceful?	1	2	3	4	5	6
e. Did you have a lot of energy?	1	2	3	4	5	6
f. Have you felt downhearted and blue?	1	2	3	4	5	6
g. Did you feel worn out?	1	2	3	4	5	6
h. Have you been a happy person?	1	2	3	4	5	6
i. Did you feel tired?	1	2	3	4	5	6

10. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives etc.)? *(circle one)*

All of the time	1
Most of the time	2
Some of the time	3
A little of the time	4
None of the time	5

11.

How TRUE or FALSE is each of the following statements for you *(circle one number on each line)*	Definitely True	Mostly True	Not Sure	Mostly False	Definitely False
a. I seem to get sick a little easier than other people	1	2	3	4	5
b. I am as healthy as anybody I know	1	2	3	4	5
c. I expect my health to get worse	1	2	3	4	5
d. My health is excellent	1	2	3	4	5

Please return to:
Frankston Pain Management
7 / 20 Clarendon St., Frankston. Vic. 3199
Tel: 9770 0522. Fax: 9770 0944

Name:.................................... Day:........................ Date: ....../ ..... /.......

ACTIVITY DIARY

Diary from (date):...to (date):...

It is important that you keep this diary for 2 days, preferably the 2 days preceding your appointment. It is easier to be accurate if you record your actions and responses several times per day (do not fill out the whole day in the evening).

Please indicate the major activity you were doing during each 4 hour period (independent of whether you had pain or not). Write what you were doing under the position you were in for that action (ie. Sitting, walking / standing, lying down).

Please indicate your mood by making a mark in the appropriate box (ie. Happy/elated, neither happy nor sad, sad and depressed).
Please record the pain intensity by inserting a tick in the appropriate pain level space, using a scale of 0 – 10 (see below).

Think of the most painful experience you have had in your life. Use that experience as the comparison to judge the pain you presently feel. Take the example of the most painful experience as an example of 10 on the scale.

0 = No pain

2 = Mild pain present, but can be easily ignored

4 = Discomforting pain present, cannot be ignored, but does not limit activity

6 = Distressing pain, cannot be ignored, interferes with concentration

8 = Horrible pain, cannot be ignored, limits all tasks, except basic needs (eating and toilet visits etc).

10 = Excruciating pain present, cannot be ignored, rest or bed rest required.

If you were taking any medications, write in amount, dosage and type of medication you took as shown in the example. Include any alcoholic beverages you have taken, listing type, size and quantity in the medication space. Use attached notes if more space is required.

Example:

	Sitting		Walking & Standing		Lying Down		Mood			Medication & Alcohol			Pain Level					
	Major Activity	Time	Major Activity	Time	Major Activity	Time	☺	😐	☹	Brand Name	Dose	Qty.	0	2	4	6	8	10
12-4 am					*Sleeping*	*4 hrs*							✓					
4-8 am	*Breakfast and reading paper*	*1 1/2 hours*	*Showering*	*30 mins.*	*Sleeping*	*2 hrs*		✓		*Panadeine Naprosyn*	*one tablet 250mg*	*2*		✓				

ACTIVITY DIARY DAY 1

Name: .... Day:........................ Date: ....../ ..... /.......

	Sitting		Walking & Standing		Lying Down		Mood			Medication & Alcohol			Pain Level					
	Major Activity	Time	Major Activity	Time	Major Activity	Time				Brand Name	Dose	Qty.	0	2	4	6	8	10
12-4 am																		
4-8 am																		
8-12 MD																		
12-4 pm																		
4-8 pm																		
8-12 MN																		

ACTIVITY DIARY DAY 2

12-4 am																		
4-8 am																		
8-12 MD																		
12-4 pm																		
4-8 pm																		
8-12 MN																		
	Total hours		**Total hours**		**Total hours**													

0 = No Pain 10 = excruciating pain