

ASSESSMENT OF PAIN

Pain and Inflammation Weekly Symptom Diary

Name: _____

Day and date: _____

Weekly Pain History

WHEN ANSWERING THE FOLLOWING QUESTIONS, PLEASE ANSWER THEM IN REFERENCE TO THE WHOLE WEEK, NOT JUST TODAY.

Thinking back over the past week:

What was the **worst pain** you experienced this week?

Please place an 'x' in the appropriate box.

No pain Worst pain ever

What was the **least pain** you experienced this week?

Please place an 'x' in the appropriate box. (If you were pain-free at times, please select '0')

No pain Worst pain ever

What was the **average pain level** you experienced this week?

Please place an 'x' in the appropriate box.

No pain Worst pain ever

On average this week, to what degree were your **normal activities impaired** by your symptoms?

Please place an 'x' in the appropriate box.

Completely normal functioning Completely unable to function normally

On average this week, to what degree was your **mood and enjoyment of life impaired** by your symptoms?

Please place an 'x' in the appropriate box.

Completely normal mood and enjoyment Severe impairment of mood and enjoyment

Please comment on the following aspects of the past week

- Did you experience any other muscle or joint symptoms this week?
eg. swelling, stiffness, heat, spasm, cramps, twitches etc
If yes, please describe. Were these symptoms better or worse than normal?

- Has your joint flexibility or ability to move in certain ways changed? Have you been able to participate in any activities you wouldn't normally? If yes, please describe.

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- Have there been any changes in the way you have used medication? If yes, please describe. Please include variations in amount of pain relief medication taken, as well as any changes in supplement use.
- Have you received any other treatments this week – eg. massage, physiotherapy etc? If yes, please describe.
- Has your lifestyle changed at all? Any changes in diet, exercise, smoking/alcohol/caffeine consumption? If yes, please describe.
- Any changes in activity levels which may have influenced your symptoms?
- Any changes in health? eg. cold and flu, headache, etc. If yes, please describe.
- Any changes in work or family demands or stress levels?
- Were there any other changes in circumstances through the course of the study which may have had effects on your health or symptoms? Please describe.

Do you experience any symptoms that were unusual for you this week?

Area of health	Please describe any changes in the following areas:
Digestion, bowel movements	
Pains, cramping, headaches	
Infections, allergies, colds and flu	
Appetite, weight	
Skin, rashes, pimples	

On average, what percentage of the prescribed doses have you taken over the week?
(100% = 6 capsules every single day)