Name of the Consumer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of CIL\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of ILS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Key: (\*1) Indicate your pain level on this scale: 1=no pain; 2= mild pain; 3=Moderate pain; 4= very painful; 5= extremely painful;

 (\*2) Indicate your pain level on this scale: 1=no pain; 2= mild pain; 3=Moderate pain; 4= very painful; 5= extremely painful.

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| --- | --- | --- | --- | --- | --- |
| **Date** | **My average level of Pain today was: (\*1)** | **What caused my pain?** | **What did I do to relieve my pain?** | **(\*2)What was my level of relief?** | **Would I try this method again?****(Yes or No)** |
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