	Mon.	Tues.	Wed.	Thurs.	Fri.	Sat.	Sun.
PAIN LEVEL (1-10)							
LOCATION OF PAIN							
TYPE OF PAIN							
PAIN TRIGGERS							
ATTEMPTED ACTIVITIES							
SKIPPED ACTIVITIES							
DID I WORK?							
HOW WAS MY MOOD?							
ATTEMPTED TREATMENT							
DID TREATMENT WORK?							
TREATMENT SIDE EFFECTS							

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Date	Type of Procedure	Medical Professional or Organization	Bill Amount	Amount Paid by Health Insurance	Amount I Paid (if Paid)

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