

The Children's Clinic of Klamath
2580 Daggett Ave.
Klamath Falls, Oregon 97601
Phone 541-884-1224

ABDOMINAL PAIN DIARY

Patient Name: _____ Date of Visit: _____

Telephone Number: _____ DOB: _____ Age: _____

Today's Vitals: Ht: _____ Wt: _____ BMI%: _____

Use this Personal Daily Diary for 2-4 weeks to help you get the most out of your next visit. The objective of using this Daily Diary is to gain a better understanding of your bowel disorder. By keeping a detailed record of stool consistency, frequency, continence, pain, diet, medication, emotional status and exercise, a clearer understanding may start to emerge for you and/or your physician to determine the best treatment options available to you. **DON'T FORGET TO BRING THIS DIARY TO YOUR FOLLOW-UP APPOINTMENT!**

DESCRIPTIONS

EXAMPLES

Stool Description

Loose; diarrhea; formed; hard, pellet-like; ribbon shaped

Symptoms

Incomplete evacuation; strong urge; straining; incontinent; stain/smear

Gas

Belching; flatus

Pain

Abdominal cramping; lower intestinal cramping; pain on either side of abdomen; tenderness (tender when touched); rectal pain (sharp, dull, burning; feels like a hard object is in rectum; cramping sensation in rectum)

Emotional Status

(How do you feel? Why?)

Fine; happy; relaxed; anxious; nervous; sad; unhappy; depressed; fatigued; tired (wake up tired, wake up during the night), mentally tired; physically tired

Stressors

Daily chores; school; job; family; social; travel; medical appointments; illness; injury; trauma; surgery; personal

Medications

Prescription/over-the-counter, including supplements and herbs; and dosages

Women

Menstrual cycle; ovulation; menstruation

Food

(List everything in detail)

Fruits; vegetables; dairy products; meat; fish; poultry; breads (whole grain, etc.); pasta; dessert; condiments (salt, pepper, catsup, sauces, spices, oils)

Beverages

Milk-dairy or soy; caffeine; decaffeinated; carbonated; diet/sugar free; fruit juices

Aggravating Factors

Food, stress, medication, menses

Alleviating factors

Food, medication, rest, bowel movement

PLEASE CALL US IF YOU HAVE ANY QUESTIONS.

541-884-1224

ABDOMINAL PAIN DIARY

Start date of pain: _____

Underwear Staining? Yes/No

Family history of abdominal pain? Yes/No

Constant?/Come and go? Yes/No

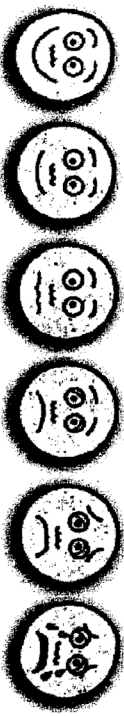
Does it prevent normal activities? Yes/No

Related to food/meals? Yes/No

Location/Does it move? Yes/No

Known stressors? Yes/No

Day of Week and Date	Time(s)	Severity* 0 - 5	Where? Home/School	Sharp/Dull/ Crampy?	BM** Hard/Soft?	Anything Make Better?	Any Other Symptoms?	Other Info?



0 No hurt
1 Hurts little bit
2 Hurts little more
3 Hurts even more
4 Hurts whole lot
5 Hurts worst

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