Astera CANCER CARE

Pain & Symptom Journal

Name: _____ Symptom(s): _____

Date and Time	Symptom Rating: Scale 0 (none) - 10 (worst)	Treatment/Intervention	Symptom Rating after Treatment (0-10)	If pain, did you have a Bowel Mov'mt today? Yes/No	Notes: Alleviating or Aggravating Factors, Other Relevant Notes

Please bring this form to your next appointment with your Oncology or Palliative Care Provider for review. Thank you!

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