



PATIENTEN-TAGEBUCH

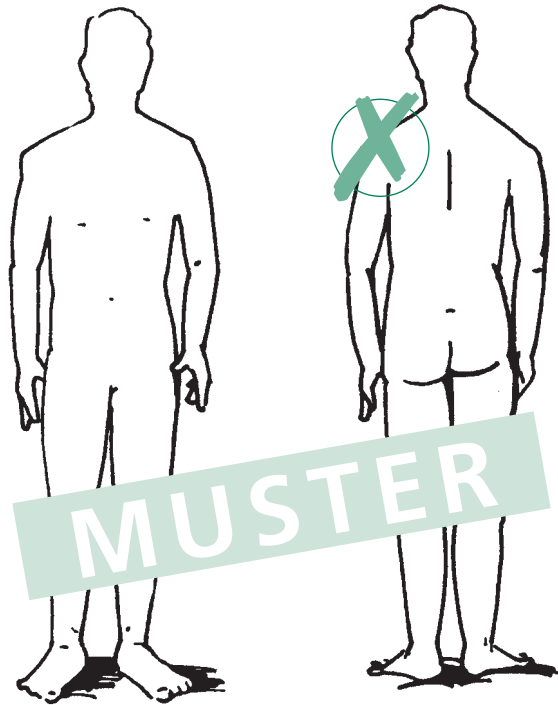
Erarbeitet von der Initiative Contra Schmerz  
in Zusammenarbeit mit der Deutschen Schmerzliga e.V.



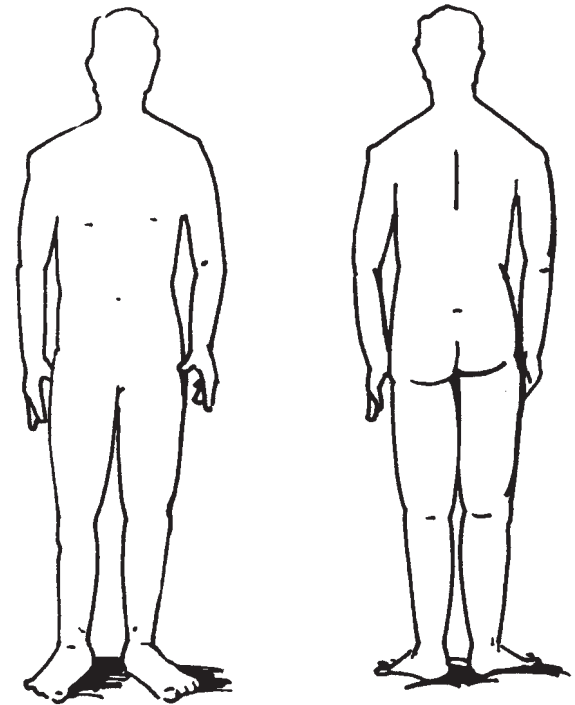


WO HABEN SIE IHREN HAUPTSCHMERZ?

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Bitte in der Abbildung markieren



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# THERAPIEPROTOKOLL SCHMERZ

Name \_\_\_\_\_

| Tag  | Montag           |                   |                   | Dienstag         |                   |                   | Mittwoch         |                   |                   | Donnerstag       |                   |                   | Freitag          |                   |                   | Samstag          |                   |                   | Sonntag          |                   |                   |   |   |
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| Zeit   | 7. <sup>00</sup> | 12. <sup>00</sup> | 19. <sup>00</sup> | 7. <sup>00</sup> | 12. <sup>00</sup> | 19. <sup>00</sup> | 7. <sup>00</sup> | 12. <sup>00</sup> | 19. <sup>00</sup> | 7. <sup>00</sup> | 12. <sup>00</sup> | 19. <sup>00</sup> | 7. <sup>00</sup> | 12. <sup>00</sup> | 19. <sup>00</sup> | 7. <sup>00</sup> | 12. <sup>00</sup> | 19. <sup>00</sup> | 7. <sup>00</sup> | 12. <sup>00</sup> | 19. <sup>00</sup> |   |   |
| Stärkster Schmerz  | 10               | 10                | 10                | 10               | 10                | 10                | 10               | 10                | 10                | 10               | 10                | 10                | 10               | 10                | 10                | 10               | 10                | 10                | 10               | 10                | 10                |   |   |
| <br>Schmerzstärke<br>↓<br>Schmerzfrei | 9                | 9                 | 9                 | 9                | 9                 | 9                 | 9                | 9                 | 9                 | 9                | 9                 | 9                 | 9                | 9                 | 9                 | 9                | 9                 | 9                 | 9                | 9                 | 9                 |   |   |
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|  | 1                | 1                 | 1                 | 1                | 1                 | 1                 | 1                | 1                 | 1                 | 1                | 1                 | 1                 | 1                | 1                 | 1                 | 1                | 1                 | 1                 | 1                | 1                 | 1                 | 1 | 1 |
|  | Schmerzfrei      | 0                 | 0                 | 0                | 0                 | 0                 | 0                | 0                 | 0                 | 0                | 0                 | 0                 | 0                | 0                 | 0                 | 0                | 0                 | 0                 | 0                | 0                 | 0                 | 0 | 0 |
| Stuhl  |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |   |   |
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Quelle: Professor T. Scholten, AK Hagen

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| Stuhl  |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |   |   |
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# TAGESABLAUF

(AM ABEND VOR DEM ARZTBESUCH AUSZUFÜLLEN)

1. Schätzen Sie die Stärke Ihres Schmerzes auf der folgenden Skala ein



2. Haben Sie die letzte Nacht ausreichend geschlafen?

- ausreichend  nicht ausreichend

3. Haben Sie heute über den ganzen Tag Schmerzen?

- nein  ja

4. Haben Ihre Schmerzen heute Ihre Aktivitäten und Bedürfnisse eingeschränkt?

- nein  ein bisschen  deutlich  stark  fast vollständig

5. Wurde Ihre Stimmung durch die Schmerzen beeinträchtigt?

- nein  ein bisschen  deutlich  stark  sehr stark

6. War es Ihnen heute möglich, die Schmerzen zu lindern?

- nein  ein bisschen  deutlich  stark  fast vollständig

7. Zusätzliche Beschwerden?

- Müdigkeit  Übelkeit  Appetitlosigkeit  Lustlosigkeit  Magenbeschwerden  
 Schlafstörungen  Schwindel  Kopfschmerzen  Verstopfung  Andere \_\_\_\_\_


8. Haben Sie zusätzliche Schmerzmedikamente benötigt?

- nein  ja \_\_\_\_\_ mal

9. Gibt es andere Ereignisse, die heute mit Ihren Schmerzen im Zusammenhang stehen? \_\_\_\_\_  
\_\_\_\_\_

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|  | 5                | 5                 | 5                 | 5                | 5                 | 5                 | 5                | 5                 | 5                 | 5                | 5                 | 5                 | 5                | 5                 | 5                 | 5                | 5                 | 5                 | 5                | 5                 | 5                 | 5 |   |
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|  | 3                | 3                 | 3                 | 3                | 3                 | 3                 | 3                | 3                 | 3                 | 3                | 3                 | 3                 | 3                | 3                 | 3                 | 3                | 3                 | 3                 | 3                | 3                 | 3                 | 3 | 3 |
|  | 2                | 2                 | 2                 | 2                | 2                 | 2                 | 2                | 2                 | 2                 | 2                | 2                 | 2                 | 2                | 2                 | 2                 | 2                | 2                 | 2                 | 2                | 2                 | 2                 | 2 | 2 |
|  | 1                | 1                 | 1                 | 1                | 1                 | 1                 | 1                | 1                 | 1                 | 1                | 1                 | 1                 | 1                | 1                 | 1                 | 1                | 1                 | 1                 | 1                | 1                 | 1                 | 1 | 1 |
|  | Schmerzfrei      | 0                 | 0                 | 0                | 0                 | 0                 | 0                | 0                 | 0                 | 0                | 0                 | 0                 | 0                | 0                 | 0                 | 0                | 0                 | 0                 | 0                | 0                 | 0                 | 0 | 0 |
| Stuhl  |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |   |   |
| Schlaf   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |   |   |
| Stimmung   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |   |   |
| Übelkeit   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |   |   |
| Zusatz-<br>medikation  | Wann?            | Was?              |                   | Wann?            | Was?              |                   | Wann?            | Was?              |                   | Wann?            | Was?              |                   | Wann?            | Was?              |                   | Wann?            | Was?              |                   | Wann?            | Was?              |                   |   |   |
|  |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |   |   |

Quelle: Professor T. Scholten, AK Hagen

# THERAPIEPROTOKOLL SCHMERZ


Name \_\_\_\_\_

| Tag  | Montag           |                   |                   | Dienstag         |                   |                   | Mittwoch         |                   |                   | Donnerstag       |                   |                   | Freitag          |                   |                   | Samstag          |                   |                   | Sonntag          |                   |                   |   |   |
|--|------------------|-------------------|-------------------|------------------|-------------------|-------------------|------------------|-------------------|-------------------|------------------|-------------------|-------------------|------------------|-------------------|-------------------|------------------|-------------------|-------------------|------------------|-------------------|-------------------|---|---|
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| Zeit   | 7. <sup>00</sup> | 12. <sup>00</sup> | 19. <sup>00</sup> | 7. <sup>00</sup> | 12. <sup>00</sup> | 19. <sup>00</sup> | 7. <sup>00</sup> | 12. <sup>00</sup> | 19. <sup>00</sup> | 7. <sup>00</sup> | 12. <sup>00</sup> | 19. <sup>00</sup> | 7. <sup>00</sup> | 12. <sup>00</sup> | 19. <sup>00</sup> | 7. <sup>00</sup> | 12. <sup>00</sup> | 19. <sup>00</sup> | 7. <sup>00</sup> | 12. <sup>00</sup> | 19. <sup>00</sup> |   |   |
| Stärkster Schmerz  | 10               | 10                | 10                | 10               | 10                | 10                | 10               | 10                | 10                | 10               | 10                | 10                | 10               | 10                | 10                | 10               | 10                | 10                | 10               | 10                | 10                |   |   |
| <br>Schmerzstärke<br>↓<br>Schmerzfrei | 9                | 9                 | 9                 | 9                | 9                 | 9                 | 9                | 9                 | 9                 | 9                | 9                 | 9                 | 9                | 9                 | 9                 | 9                | 9                 | 9                 | 9                | 9                 | 9                 |   |   |
|  | 8                | 8                 | 8                 | 8                | 8                 | 8                 | 8                | 8                 | 8                 | 8                | 8                 | 8                 | 8                | 8                 | 8                 | 8                | 8                 | 8                 | 8                | 8                 | 8                 | 8 |   |
|  | 7                | 7                 | 7                 | 7                | 7                 | 7                 | 7                | 7                 | 7                 | 7                | 7                 | 7                 | 7                | 7                 | 7                 | 7                | 7                 | 7                 | 7                | 7                 | 7                 | 7 |   |
|  | 6                | 6                 | 6                 | 6                | 6                 | 6                 | 6                | 6                 | 6                 | 6                | 6                 | 6                 | 6                | 6                 | 6                 | 6                | 6                 | 6                 | 6                | 6                 | 6                 | 6 |   |
|  | 5                | 5                 | 5                 | 5                | 5                 | 5                 | 5                | 5                 | 5                 | 5                | 5                 | 5                 | 5                | 5                 | 5                 | 5                | 5                 | 5                 | 5                | 5                 | 5                 | 5 |   |
|  | 4                | 4                 | 4                 | 4                | 4                 | 4                 | 4                | 4                 | 4                 | 4                | 4                 | 4                 | 4                | 4                 | 4                 | 4                | 4                 | 4                 | 4                | 4                 | 4                 | 4 | 4 |
|  | 3                | 3                 | 3                 | 3                | 3                 | 3                 | 3                | 3                 | 3                 | 3                | 3                 | 3                 | 3                | 3                 | 3                 | 3                | 3                 | 3                 | 3                | 3                 | 3                 | 3 | 3 |
|  | 2                | 2                 | 2                 | 2                | 2                 | 2                 | 2                | 2                 | 2                 | 2                | 2                 | 2                 | 2                | 2                 | 2                 | 2                | 2                 | 2                 | 2                | 2                 | 2                 | 2 | 2 |
|  | 1                | 1                 | 1                 | 1                | 1                 | 1                 | 1                | 1                 | 1                 | 1                | 1                 | 1                 | 1                | 1                 | 1                 | 1                | 1                 | 1                 | 1                | 1                 | 1                 | 1 | 1 |
|  | Schmerzfrei      | 0                 | 0                 | 0                | 0                 | 0                 | 0                | 0                 | 0                 | 0                | 0                 | 0                 | 0                | 0                 | 0                 | 0                | 0                 | 0                 | 0                | 0                 | 0                 | 0 | 0 |
| Stuhl  |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |   |   |
| Schlaf   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |   |   |
| Stimmung   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |   |   |
| Übelkeit   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |   |   |
| Zusatz-<br>medikation  | Wann?            | Was?              |                   | Wann?            | Was?              |                   | Wann?            | Was?              |                   | Wann?            | Was?              |                   | Wann?            | Was?              |                   | Wann?            | Was?              |                   | Wann?            | Was?              |                   |   |   |
|  |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |   |   |

Quelle: Professor T. Scholten, AK Hagen

# THERAPIEPROTOKOLL SCHMERZ

Name \_\_\_\_\_

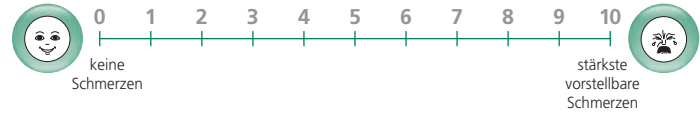
| Tag  | Montag           |                   |                   | Dienstag         |                   |                   | Mittwoch         |                   |                   | Donnerstag       |                   |                   | Freitag          |                   |                   | Samstag          |                   |                   | Sonntag          |                   |                   |   |   |
|--|------------------|-------------------|-------------------|------------------|-------------------|-------------------|------------------|-------------------|-------------------|------------------|-------------------|-------------------|------------------|-------------------|-------------------|------------------|-------------------|-------------------|------------------|-------------------|-------------------|---|---|
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| Zeit   | 7. <sup>00</sup> | 12. <sup>00</sup> | 19. <sup>00</sup> | 7. <sup>00</sup> | 12. <sup>00</sup> | 19. <sup>00</sup> | 7. <sup>00</sup> | 12. <sup>00</sup> | 19. <sup>00</sup> | 7. <sup>00</sup> | 12. <sup>00</sup> | 19. <sup>00</sup> | 7. <sup>00</sup> | 12. <sup>00</sup> | 19. <sup>00</sup> | 7. <sup>00</sup> | 12. <sup>00</sup> | 19. <sup>00</sup> | 7. <sup>00</sup> | 12. <sup>00</sup> | 19. <sup>00</sup> |   |   |
| Stärkster Schmerz  | 10               | 10                | 10                | 10               | 10                | 10                | 10               | 10                | 10                | 10               | 10                | 10                | 10               | 10                | 10                | 10               | 10                | 10                | 10               | 10                | 10                |   |   |
| <br>Schmerzstärke<br>↓<br>Schmerzfrei | 9                | 9                 | 9                 | 9                | 9                 | 9                 | 9                | 9                 | 9                 | 9                | 9                 | 9                 | 9                | 9                 | 9                 | 9                | 9                 | 9                 | 9                | 9                 | 9                 |   |   |
|  | 8                | 8                 | 8                 | 8                | 8                 | 8                 | 8                | 8                 | 8                 | 8                | 8                 | 8                 | 8                | 8                 | 8                 | 8                | 8                 | 8                 | 8                | 8                 | 8                 | 8 |   |
|  | 7                | 7                 | 7                 | 7                | 7                 | 7                 | 7                | 7                 | 7                 | 7                | 7                 | 7                 | 7                | 7                 | 7                 | 7                | 7                 | 7                 | 7                | 7                 | 7                 | 7 |   |
|  | 6                | 6                 | 6                 | 6                | 6                 | 6                 | 6                | 6                 | 6                 | 6                | 6                 | 6                 | 6                | 6                 | 6                 | 6                | 6                 | 6                 | 6                | 6                 | 6                 | 6 |   |
|  | 5                | 5                 | 5                 | 5                | 5                 | 5                 | 5                | 5                 | 5                 | 5                | 5                 | 5                 | 5                | 5                 | 5                 | 5                | 5                 | 5                 | 5                | 5                 | 5                 | 5 |   |
|  | 4                | 4                 | 4                 | 4                | 4                 | 4                 | 4                | 4                 | 4                 | 4                | 4                 | 4                 | 4                | 4                 | 4                 | 4                | 4                 | 4                 | 4                | 4                 | 4                 | 4 | 4 |
|  | 3                | 3                 | 3                 | 3                | 3                 | 3                 | 3                | 3                 | 3                 | 3                | 3                 | 3                 | 3                | 3                 | 3                 | 3                | 3                 | 3                 | 3                | 3                 | 3                 | 3 | 3 |
|  | 2                | 2                 | 2                 | 2                | 2                 | 2                 | 2                | 2                 | 2                 | 2                | 2                 | 2                 | 2                | 2                 | 2                 | 2                | 2                 | 2                 | 2                | 2                 | 2                 | 2 | 2 |
|  | 1                | 1                 | 1                 | 1                | 1                 | 1                 | 1                | 1                 | 1                 | 1                | 1                 | 1                 | 1                | 1                 | 1                 | 1                | 1                 | 1                 | 1                | 1                 | 1                 | 1 | 1 |
|  | Schmerzfrei      | 0                 | 0                 | 0                | 0                 | 0                 | 0                | 0                 | 0                 | 0                | 0                 | 0                 | 0                | 0                 | 0                 | 0                | 0                 | 0                 | 0                | 0                 | 0                 | 0 | 0 |
| Stuhl  |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |   |   |
| Schlaf   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |   |   |
| Stimmung   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |   |   |
| Übelkeit   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |   |   |
| Zusatz-<br>medikation  | Wann?            | Was?              |                   | Wann?            | Was?              |                   | Wann?            | Was?              |                   | Wann?            | Was?              |                   | Wann?            | Was?              |                   | Wann?            | Was?              |                   | Wann?            | Was?              |                   |   |   |
|  |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |   |   |

Quelle: Professor T. Scholten, AK Hagen

# TAGESABLAUF

(AM ABEND VOR DEM ARZTBESUCH AUSZUFÜLLEN)

1. Schätzen Sie die Stärke Ihres Schmerzes auf der folgenden Skala ein



2. Haben Sie die letzte Nacht ausreichend geschlafen?

- ausreichend  nicht ausreichend

3. Haben Sie heute über den ganzen Tag Schmerzen?

- nein  ja

4. Haben Ihre Schmerzen heute Ihre Aktivitäten und Bedürfnisse eingeschränkt?

- nein  ein bisschen  deutlich  stark  fast vollständig

5. Wurde Ihre Stimmung durch die Schmerzen beeinträchtigt?

- nein  ein bisschen  deutlich  stark  sehr stark

6. War es Ihnen heute möglich, die Schmerzen zu lindern?

- nein  ein bisschen  deutlich  stark  fast vollständig

7. Zusätzliche Beschwerden?

- Müdigkeit  Übelkeit  Appetitlosigkeit  Lustlosigkeit  Magenbeschwerden  
 Schlafstörungen  Schwindel  Kopfschmerzen  Verstopfung  Andere \_\_\_\_\_



8. Haben Sie zusätzliche Schmerzmedikamente benötigt?

- nein  ja \_\_\_\_\_ mal

9. Gibt es andere Ereignisse, die heute mit Ihren Schmerzen im Zusammenhang stehen? \_\_\_\_\_  
\_\_\_\_\_



# THERAPIEPROTOKOLL SCHMERZ

Name \_\_\_\_\_

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|--|------------------|-------------------|-------------------|------------------|-------------------|-------------------|------------------|-------------------|-------------------|------------------|-------------------|-------------------|------------------|-------------------|-------------------|------------------|-------------------|-------------------|------------------|-------------------|-------------------|----|---|
| Datum  |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |    |   |
| Zeit   | 7. <sup>00</sup> | 12. <sup>00</sup> | 19. <sup>00</sup> | 7. <sup>00</sup> | 12. <sup>00</sup> | 19. <sup>00</sup> | 7. <sup>00</sup> | 12. <sup>00</sup> | 19. <sup>00</sup> | 7. <sup>00</sup> | 12. <sup>00</sup> | 19. <sup>00</sup> | 7. <sup>00</sup> | 12. <sup>00</sup> | 19. <sup>00</sup> | 7. <sup>00</sup> | 12. <sup>00</sup> | 19. <sup>00</sup> | 7. <sup>00</sup> | 12. <sup>00</sup> | 19. <sup>00</sup> |    |   |
| Stärkster Schmerz  | 10               | 10                | 10                | 10               | 10                | 10                | 10               | 10                | 10                | 10               | 10                | 10                | 10               | 10                | 10                | 10               | 10                | 10                | 10               | 10                | 10                | 10 |   |
| <br>Schmerzstärke<br><br>Schmerzfrei | 9                | 9                 | 9                 | 9                | 9                 | 9                 | 9                | 9                 | 9                 | 9                | 9                 | 9                 | 9                | 9                 | 9                 | 9                | 9                 | 9                 | 9                | 9                 | 9                 |    |   |
|  | 8                | 8                 | 8                 | 8                | 8                 | 8                 | 8                | 8                 | 8                 | 8                | 8                 | 8                 | 8                | 8                 | 8                 | 8                | 8                 | 8                 | 8                | 8                 | 8                 | 8  |   |
|  | 7                | 7                 | 7                 | 7                | 7                 | 7                 | 7                | 7                 | 7                 | 7                | 7                 | 7                 | 7                | 7                 | 7                 | 7                | 7                 | 7                 | 7                | 7                 | 7                 | 7  |   |
|  | 6                | 6                 | 6                 | 6                | 6                 | 6                 | 6                | 6                 | 6                 | 6                | 6                 | 6                 | 6                | 6                 | 6                 | 6                | 6                 | 6                 | 6                | 6                 | 6                 | 6  |   |
|  | 5                | 5                 | 5                 | 5                | 5                 | 5                 | 5                | 5                 | 5                 | 5                | 5                 | 5                 | 5                | 5                 | 5                 | 5                | 5                 | 5                 | 5                | 5                 | 5                 | 5  |   |
|  | 4                | 4                 | 4                 | 4                | 4                 | 4                 | 4                | 4                 | 4                 | 4                | 4                 | 4                 | 4                | 4                 | 4                 | 4                | 4                 | 4                 | 4                | 4                 | 4                 | 4  | 4 |
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|  | 2                | 2                 | 2                 | 2                | 2                 | 2                 | 2                | 2                 | 2                 | 2                | 2                 | 2                 | 2                | 2                 | 2                 | 2                | 2                 | 2                 | 2                | 2                 | 2                 | 2  | 2 |
|  | 1                | 1                 | 1                 | 1                | 1                 | 1                 | 1                | 1                 | 1                 | 1                | 1                 | 1                 | 1                | 1                 | 1                 | 1                | 1                 | 1                 | 1                | 1                 | 1                 | 1  | 1 |
|  | Schmerzfrei      | 0                 | 0                 | 0                | 0                 | 0                 | 0                | 0                 | 0                 | 0                | 0                 | 0                 | 0                | 0                 | 0                 | 0                | 0                 | 0                 | 0                | 0                 | 0                 | 0  | 0 |
| Stuhl  |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |    |   |
| Schlaf   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |    |   |
| Stimmung   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |    |   |
| Übelkeit   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |    |   |
| Zusatz-<br>medikation  | Wann?            | Was?              |                   | Wann?            | Was?              |                   | Wann?            | Was?              |                   | Wann?            | Was?              |                   | Wann?            | Was?              |                   | Wann?            | Was?              |                   | Wann?            | Was?              |                   |    |   |
|  |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |    |   |


# THERAPIEPROTOKOLL SCHMERZ

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|--|------------------|-------------------|-------------------|------------------|-------------------|-------------------|------------------|-------------------|-------------------|------------------|-------------------|-------------------|------------------|-------------------|-------------------|------------------|-------------------|-------------------|------------------|-------------------|-------------------|----|---|
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| Zeit   | 7. <sup>00</sup> | 12. <sup>00</sup> | 19. <sup>00</sup> | 7. <sup>00</sup> | 12. <sup>00</sup> | 19. <sup>00</sup> | 7. <sup>00</sup> | 12. <sup>00</sup> | 19. <sup>00</sup> | 7. <sup>00</sup> | 12. <sup>00</sup> | 19. <sup>00</sup> | 7. <sup>00</sup> | 12. <sup>00</sup> | 19. <sup>00</sup> | 7. <sup>00</sup> | 12. <sup>00</sup> | 19. <sup>00</sup> | 7. <sup>00</sup> | 12. <sup>00</sup> | 19. <sup>00</sup> |    |   |
| Stärkster Schmerz  | 10               | 10                | 10                | 10               | 10                | 10                | 10               | 10                | 10                | 10               | 10                | 10                | 10               | 10                | 10                | 10               | 10                | 10                | 10               | 10                | 10                | 10 |   |
| <br>Schmerzstärke<br><br>Schmerzfrei | 9                | 9                 | 9                 | 9                | 9                 | 9                 | 9                | 9                 | 9                 | 9                | 9                 | 9                 | 9                | 9                 | 9                 | 9                | 9                 | 9                 | 9                | 9                 | 9                 |    |   |
|  | 8                | 8                 | 8                 | 8                | 8                 | 8                 | 8                | 8                 | 8                 | 8                | 8                 | 8                 | 8                | 8                 | 8                 | 8                | 8                 | 8                 | 8                | 8                 | 8                 | 8  |   |
|  | 7                | 7                 | 7                 | 7                | 7                 | 7                 | 7                | 7                 | 7                 | 7                | 7                 | 7                 | 7                | 7                 | 7                 | 7                | 7                 | 7                 | 7                | 7                 | 7                 | 7  |   |
|  | 6                | 6                 | 6                 | 6                | 6                 | 6                 | 6                | 6                 | 6                 | 6                | 6                 | 6                 | 6                | 6                 | 6                 | 6                | 6                 | 6                 | 6                | 6                 | 6                 | 6  |   |
|  | 5                | 5                 | 5                 | 5                | 5                 | 5                 | 5                | 5                 | 5                 | 5                | 5                 | 5                 | 5                | 5                 | 5                 | 5                | 5                 | 5                 | 5                | 5                 | 5                 | 5  |   |
|  | 4                | 4                 | 4                 | 4                | 4                 | 4                 | 4                | 4                 | 4                 | 4                | 4                 | 4                 | 4                | 4                 | 4                 | 4                | 4                 | 4                 | 4                | 4                 | 4                 | 4  | 4 |
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|  | 2                | 2                 | 2                 | 2                | 2                 | 2                 | 2                | 2                 | 2                 | 2                | 2                 | 2                 | 2                | 2                 | 2                 | 2                | 2                 | 2                 | 2                | 2                 | 2                 | 2  | 2 |
|  | 1                | 1                 | 1                 | 1                | 1                 | 1                 | 1                | 1                 | 1                 | 1                | 1                 | 1                 | 1                | 1                 | 1                 | 1                | 1                 | 1                 | 1                | 1                 | 1                 | 1  | 1 |
|  | Schmerzfrei      | 0                 | 0                 | 0                | 0                 | 0                 | 0                | 0                 | 0                 | 0                | 0                 | 0                 | 0                | 0                 | 0                 | 0                | 0                 | 0                 | 0                | 0                 | 0                 | 0  | 0 |
| Stuhl  |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |    |   |
| Schlaf   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |    |   |
| Stimmung   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |    |   |
| Übelkeit   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |    |   |
| Zusatz-<br>medikation  | Wann?            | Was?              |                   | Wann?            | Was?              |                   | Wann?            | Was?              |                   | Wann?            | Was?              |                   | Wann?            | Was?              |                   | Wann?            | Was?              |                   | Wann?            | Was?              |                   |    |   |
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|--|------------------|-------------------|-------------------|------------------|-------------------|-------------------|------------------|-------------------|-------------------|------------------|-------------------|-------------------|------------------|-------------------|-------------------|------------------|-------------------|-------------------|------------------|-------------------|-------------------|---|---|
| Datum  |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |   |   |
| Zeit   | 7. <sup>00</sup> | 12. <sup>00</sup> | 19. <sup>00</sup> | 7. <sup>00</sup> | 12. <sup>00</sup> | 19. <sup>00</sup> | 7. <sup>00</sup> | 12. <sup>00</sup> | 19. <sup>00</sup> | 7. <sup>00</sup> | 12. <sup>00</sup> | 19. <sup>00</sup> | 7. <sup>00</sup> | 12. <sup>00</sup> | 19. <sup>00</sup> | 7. <sup>00</sup> | 12. <sup>00</sup> | 19. <sup>00</sup> | 7. <sup>00</sup> | 12. <sup>00</sup> | 19. <sup>00</sup> |   |   |
| Stärkster Schmerz  | 10               | 10                | 10                | 10               | 10                | 10                | 10               | 10                | 10                | 10               | 10                | 10                | 10               | 10                | 10                | 10               | 10                | 10                | 10               | 10                | 10                |   |   |
| <br>Schmerzstärke<br>↓<br>Schmerzfrei | 9                | 9                 | 9                 | 9                | 9                 | 9                 | 9                | 9                 | 9                 | 9                | 9                 | 9                 | 9                | 9                 | 9                 | 9                | 9                 | 9                 | 9                | 9                 | 9                 |   |   |
|  | 8                | 8                 | 8                 | 8                | 8                 | 8                 | 8                | 8                 | 8                 | 8                | 8                 | 8                 | 8                | 8                 | 8                 | 8                | 8                 | 8                 | 8                | 8                 | 8                 | 8 |   |
|  | 7                | 7                 | 7                 | 7                | 7                 | 7                 | 7                | 7                 | 7                 | 7                | 7                 | 7                 | 7                | 7                 | 7                 | 7                | 7                 | 7                 | 7                | 7                 | 7                 | 7 |   |
|  | 6                | 6                 | 6                 | 6                | 6                 | 6                 | 6                | 6                 | 6                 | 6                | 6                 | 6                 | 6                | 6                 | 6                 | 6                | 6                 | 6                 | 6                | 6                 | 6                 | 6 |   |
|  | 5                | 5                 | 5                 | 5                | 5                 | 5                 | 5                | 5                 | 5                 | 5                | 5                 | 5                 | 5                | 5                 | 5                 | 5                | 5                 | 5                 | 5                | 5                 | 5                 | 5 |   |
|  | 4                | 4                 | 4                 | 4                | 4                 | 4                 | 4                | 4                 | 4                 | 4                | 4                 | 4                 | 4                | 4                 | 4                 | 4                | 4                 | 4                 | 4                | 4                 | 4                 | 4 | 4 |
|  | 3                | 3                 | 3                 | 3                | 3                 | 3                 | 3                | 3                 | 3                 | 3                | 3                 | 3                 | 3                | 3                 | 3                 | 3                | 3                 | 3                 | 3                | 3                 | 3                 | 3 | 3 |
|  | 2                | 2                 | 2                 | 2                | 2                 | 2                 | 2                | 2                 | 2                 | 2                | 2                 | 2                 | 2                | 2                 | 2                 | 2                | 2                 | 2                 | 2                | 2                 | 2                 | 2 | 2 |
|  | 1                | 1                 | 1                 | 1                | 1                 | 1                 | 1                | 1                 | 1                 | 1                | 1                 | 1                 | 1                | 1                 | 1                 | 1                | 1                 | 1                 | 1                | 1                 | 1                 | 1 | 1 |
|  | Schmerzfrei      | 0                 | 0                 | 0                | 0                 | 0                 | 0                | 0                 | 0                 | 0                | 0                 | 0                 | 0                | 0                 | 0                 | 0                | 0                 | 0                 | 0                | 0                 | 0                 | 0 | 0 |
| Stuhl  |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |   |   |
| Schlaf   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |   |   |
| Stimmung   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |   |   |
| Übelkeit   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |   |   |
| Zusatz-<br>medikation  | Wann?            | Was?              |                   | Wann?            | Was?              |                   | Wann?            | Was?              |                   | Wann?            | Was?              |                   | Wann?            | Was?              |                   | Wann?            | Was?              |                   | Wann?            | Was?              |                   |   |   |
|  |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |   |   |

# THERAPIEPROTOKOLL SCHMERZ

Name \_\_\_\_\_

| Tag  | Montag           |                   |                   | Dienstag         |                   |                   | Mittwoch         |                   |                   | Donnerstag       |                   |                   | Freitag          |                   |                   | Samstag          |                   |                   | Sonntag          |                   |                   |   |   |
|--|------------------|-------------------|-------------------|------------------|-------------------|-------------------|------------------|-------------------|-------------------|------------------|-------------------|-------------------|------------------|-------------------|-------------------|------------------|-------------------|-------------------|------------------|-------------------|-------------------|---|---|
| Datum  |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |   |   |
| Zeit   | 7. <sup>00</sup> | 12. <sup>00</sup> | 19. <sup>00</sup> | 7. <sup>00</sup> | 12. <sup>00</sup> | 19. <sup>00</sup> | 7. <sup>00</sup> | 12. <sup>00</sup> | 19. <sup>00</sup> | 7. <sup>00</sup> | 12. <sup>00</sup> | 19. <sup>00</sup> | 7. <sup>00</sup> | 12. <sup>00</sup> | 19. <sup>00</sup> | 7. <sup>00</sup> | 12. <sup>00</sup> | 19. <sup>00</sup> | 7. <sup>00</sup> | 12. <sup>00</sup> | 19. <sup>00</sup> |   |   |
| Stärkster Schmerz  | 10               | 10                | 10                | 10               | 10                | 10                | 10               | 10                | 10                | 10               | 10                | 10                | 10               | 10                | 10                | 10               | 10                | 10                | 10               | 10                | 10                |   |   |
| <br>Schmerzstärke<br>↓<br>Schmerzfrei | 9                | 9                 | 9                 | 9                | 9                 | 9                 | 9                | 9                 | 9                 | 9                | 9                 | 9                 | 9                | 9                 | 9                 | 9                | 9                 | 9                 | 9                | 9                 | 9                 |   |   |
|  | 8                | 8                 | 8                 | 8                | 8                 | 8                 | 8                | 8                 | 8                 | 8                | 8                 | 8                 | 8                | 8                 | 8                 | 8                | 8                 | 8                 | 8                | 8                 | 8                 | 8 |   |
|  | 7                | 7                 | 7                 | 7                | 7                 | 7                 | 7                | 7                 | 7                 | 7                | 7                 | 7                 | 7                | 7                 | 7                 | 7                | 7                 | 7                 | 7                | 7                 | 7                 | 7 |   |
|  | 6                | 6                 | 6                 | 6                | 6                 | 6                 | 6                | 6                 | 6                 | 6                | 6                 | 6                 | 6                | 6                 | 6                 | 6                | 6                 | 6                 | 6                | 6                 | 6                 | 6 |   |
|  | 5                | 5                 | 5                 | 5                | 5                 | 5                 | 5                | 5                 | 5                 | 5                | 5                 | 5                 | 5                | 5                 | 5                 | 5                | 5                 | 5                 | 5                | 5                 | 5                 | 5 |   |
|  | 4                | 4                 | 4                 | 4                | 4                 | 4                 | 4                | 4                 | 4                 | 4                | 4                 | 4                 | 4                | 4                 | 4                 | 4                | 4                 | 4                 | 4                | 4                 | 4                 | 4 | 4 |
|  | 3                | 3                 | 3                 | 3                | 3                 | 3                 | 3                | 3                 | 3                 | 3                | 3                 | 3                 | 3                | 3                 | 3                 | 3                | 3                 | 3                 | 3                | 3                 | 3                 | 3 | 3 |
|  | 2                | 2                 | 2                 | 2                | 2                 | 2                 | 2                | 2                 | 2                 | 2                | 2                 | 2                 | 2                | 2                 | 2                 | 2                | 2                 | 2                 | 2                | 2                 | 2                 | 2 | 2 |
|  | 1                | 1                 | 1                 | 1                | 1                 | 1                 | 1                | 1                 | 1                 | 1                | 1                 | 1                 | 1                | 1                 | 1                 | 1                | 1                 | 1                 | 1                | 1                 | 1                 | 1 | 1 |
|  | Schmerzfrei      | 0                 | 0                 | 0                | 0                 | 0                 | 0                | 0                 | 0                 | 0                | 0                 | 0                 | 0                | 0                 | 0                 | 0                | 0                 | 0                 | 0                | 0                 | 0                 | 0 | 0 |
| Stuhl  |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |   |   |
| Schlaf   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |   |   |
| Stimmung   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |   |   |
| Übelkeit   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |   |   |
| Zusatz-<br>medikation  | Wann?            | Was?              |                   | Wann?            | Was?              |                   | Wann?            | Was?              |                   | Wann?            | Was?              |                   | Wann?            | Was?              |                   | Wann?            | Was?              |                   | Wann?            | Was?              |                   |   |   |
|  |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |                  |                   |                   |   |   |

Quelle: Professor T. Scholten, AK Hagen

# TAGESABLAUF

(AM ABEND VOR DEM ARZTBESUCH AUSZUFÜLLEN)

- Schätzen Sie die Stärke Ihres Schmerzes auf der folgenden Skala ein
- Haben Sie die letzte Nacht ausreichend geschlafen?  
 ausreichend  nicht ausreichend
- Haben Sie heute über den ganzen Tag Schmerzen?  
 nein  ja
- Haben Ihre Schmerzen heute Ihre Aktivitäten und Bedürfnisse eingeschränkt?  
 nein  ein bisschen  deutlich  stark  fast vollständig
- Wurde Ihre Stimmung durch die Schmerzen beeinträchtigt?  
 nein  ein bisschen  deutlich  stark  sehr stark
- War es Ihnen heute möglich, die Schmerzen zu lindern?  
 nein  ein bisschen  deutlich  stark  fast vollständig
- Zusätzliche Beschwerden?  
 Müdigkeit  Übelkeit  Appetitlosigkeit  Lustlosigkeit  Magenbeschwerden  
 Schlafstörungen  Schwindel  Kopfschmerzen  Verstopfung  Andere \_\_\_\_\_
- Haben Sie zusätzliche Schmerzmedikamente benötigt?  
 nein  ja \_\_\_\_\_ mal
- Gibt es andere Ereignisse, die heute mit Ihren Schmerzen im Zusammenhang stehen? \_\_\_\_\_  
\_\_\_\_\_



