


































































SCHMERZVERLAUFBEOBACHTUNG BEI SELBSTAUSKUNFT

Name: _____

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Datum							
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Stärkster Schmerz 	10 10 10	10 10 10	10 10 10	10 10 10	10 10 10	10 10 10	10 10 10
Schmerzstärke	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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Schmerzfrei	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0
Stuhl	  	  	  	  	  	  	  
Schlaf	  	  	  	  	  	  	  
Stimmung	  	  	  	  	  	  	  
Zusatz-medikation	Wann? Was?	Wann? Was?	Wann? Was?	Wann? Was?	Wann? Was?	Wann? Was?	Wann? Was?