

Daily Spine Surgery Recovery Journal

AAOS PAIN MANAGEMENT RESOURCE CENTER

Patient Name: _____

Surgery Date: _____

Today's Date: _____

Days Since Surgery: _____

1. Pain and Comfort

Pain level (0 to 10): _____

Where is your pain today?

Back Leg Incision Other:

How is your pain compared with yesterday?

Better Same Worse

What helped your pain today?

Medication Rest Ice Movement

Other: _____

How did you sleep last night?

Good Okay Poor

Notes:

2. Movement and Activity

Walking today (minutes or steps): _____

Today I was able to (check all that apply):

Get out of bed safely

Sit comfortably

Stand without help

Walk on my own

Did you follow movement precautions?

Yes No

⚠ (Avoid bending, lifting, or twisting unless your doctor clears you)

Notes (progress or difficulty): _____

3. Incision and Wound Check

How does your incision look today?

Clean Dry Red Swollen Draining

Do you have new pain at the incision?

No Yes: _____

Notes: _____

4. Nerve Symptoms

Did you have any of these today?

No numbness or tingling

Numbness

Tingling

Weakness

Where are these symptoms? _____

Notes: _____

5. Nutrition and Hydration

Fluids today:

Less than 4 cups 4 to 6 cups 6 to 8 cups More than 8 cups

Meals:

Ate well Ate a little Poor appetite

Did you eat protein (important for healing)?

Yes No

Notes: _____

6. Bowel and Bladder

Urination:

Normal Difficult

Bowel movement:

Today Yesterday Not in 2+ days

Notes: _____

7. Energy and Recovery

Energy level today:

Low Moderate Improving

Did you rest when needed?

Yes No

Notes: _____

8. Mood and Emotional Well-being

Mood today:

Good Okay Low Anxious

Stress level:

Low Moderate High

Notes: _____

9. Warning Signs Check

Did you have any of the following today?

- Fever
- Increasing pain
- New weakness
- Trouble walking
- Incision drainage
- Trouble breathing
- Loss of bowel/bladder control

IMPORTANT: If you checked ANY of these, contact your care team immediately.

10. Today's Wins (Small Progress Matters!)

What went better today?

11. Questions for My Care Team

Write down questions for your next visit.

Optional Weekly Reflection (every 7 days)

My overall progress: Improving No change Setback

I can do more this week than last week: Yes No

Biggest improvement: _____

Biggest concern: _____

Tip for Patients

Bring this journal (or photos of it) to your follow-up visits.

It helps your care team see patterns and support your recovery.

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