Pain Notebook

NAME

ADDRESS

CITY

STATE, ZIP

EMAIL

PHONE

American Pain Foundation

The Importance of Managing Your Pain

Good pain management starts with good communication between you and your healthcare provider. This notebook will show you how to work together.

Understanding that chronic pain is a disease in itself—and one that is harmful to the body—is a new way of thinking. Until recently, pain was considered only as a symptom of a disease or condition, or just a natural part of aging.

Today, we know that pain should never be ignored. It should be assessed thoroughly and treated aggressively, and in some cases managed as a chronic condition. We've learned that when pain is managed, stress is reduced, and the body heals faster.

When people with pain work together with their healthcare professionals and take an active role in their pain management, they get the best results possible—less pain and more involvement in life.

TYPES OF PAIN

Understanding the different kinds of pain that you may be experiencing—and the terms used to describe them—will help you communicate better with your medical team. Using the right terms (described below) and the Pain Notebook when meeting with your medical team will help them best determine the most specific and effective plan to manage your pain.

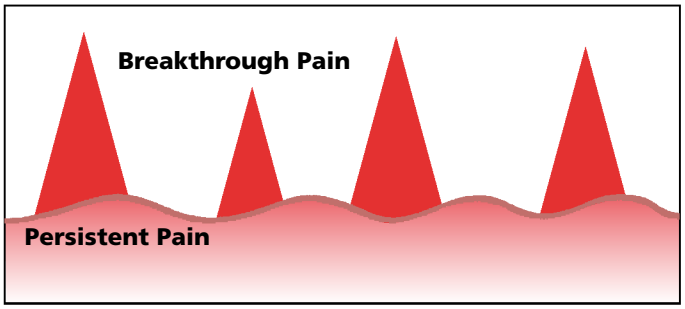
Acute Pain comes on suddenly, usually from an injury or surgery. It can usually be treated and lasts for a short period of time.

Chronic Pain lasts beyond the usual healing time for an illness or injury. It can last from months to years. At times it can go away completely, or it can remain constant. **Types of chronic pain:**

Intermittent Pain is episodic. It may occur in waves or patterns. Intermittent pain is often treated with NSAIDs, adjuvant medicines, and non-drug therapies. Moderate to severe intermittent pain may be treated with short-acting opioids.

Persistent pain lasts 12 or more hours every day for more than three months. It is usually treated with medicine that you take at specific times every day so that you get pain relief throughout the day. Moderate to severe pain may be treated with opioids.

Breakthrough pain comes up quickly or "breaks through" the medicine you are taking to relieve your persistent pain. It can occur many times during the day. This type of pain can be treated with specific medicines used as you need them to get quick pain relief.



The goal of pain management is to treat pain until optimal relief and functional outcomes are reached.

How can I best communicate with my healthcare team?

You and the members of your healthcare team are partners in managing your pain. Here are some tips to help that partnership work well:

Be prepared and organized:

- Use the Pain Notebook as much as you can. It will give your medical team valuable information about your pain experience between office or clinic visits.
- Write down your questions. List your most important concerns first. Bring them to the healthcare provider's office or the clinic, and check them off as they're answered.

Be honest and open. Don't hold back. Remember:

- You have the information your medical team needs to be able to relieve your pain.
- You have no reason to be embarrassed or afraid to talk to your medical team. They will take the time to listen to your concerns.

Take notes during your visit:

- Include concerns about your pain and other issues related to your care before the visit ends (refer to your list of questions).
- Think about bringing a family member or good friend to take notes. The stress of a medical visit can sometimes make people miss important information.

Make sure you understand all instructions and explanations:

- If something isn't clear, ask your healthcare provider to explain it again in a different way until you're sure you understand.
- Before you leave, repeat what you heard back to the person who gave you the instructions. This is a final check to make sure you understand all the details and that your notes are accurate.

Follow the agreed treatment plan:

- Don't make changes without checking with your healthcare provider.
- If the plan isn't working well, call the office or clinic as soon as possible and explain the problem.

Pain Care Bill of Rights

As a Person with Pain, You Have The Right to:

- Have your report of pain taken seriously and to be treated with dignity and respect by doctors, nurses, pharmacists, and other healthcare professionals.
- Have your pain thoroughly assessed and promptly treated.
- Be informed by your healthcare provider about what may be causing your pain, possible treatments, and the benefits, risks, and costs of each.
- Participate actively in decisions about how to manage your pain.
- Have your pain reassessed regularly and your treatment adjusted if your pain has not been eased.
- Be referred to a pain specialist if your pain persists.
- Get clear and prompt answers to your questions, take time to make decisions, and refuse a particular type of treatment if you choose.

Although not always required by law, these are the rights you should expect for your pain care.

Using Your Pain Notebook

Why Use the Pain Notebook?

You are the expert on your own pain.

You have the right to have your pain treated.

Your Pain Notebook will help you keep a record of your pain experience throughout the day.

Keeping track of what things make your pain better or worse will help your medical team find the best ways to treat your pain.

This is why it is so important to use your Pain Notebook every day—especially on the days you are most in pain.

Your physical and emotional comfort are important parts of treating your pain. Your Pain Notebook has important information that will help your medical team find the most effective ways to treat your pain.

How to Use Your Pain Notebook

Use your Pain Notebook in a way that is most helpful to you. You do not have to fill in all the parts. And if you need additional pages, you can print them from the APF website: www.painfoundation.org.

Keep your Pain Notebook in one particular place—one that is handy and easy to remember.

Find a comfortable place to sit so that you can write down your information.

Write down as much information as you can think of about your pain.

Each two-page daily section of your notebook has three parts.

The first section, the **Daily Pain Chart**, helps you create a visual picture of your daily pain experience. Follow your pain level throughout the day choosing several times that fit your routine, like when you get in or out of bed, eat meals, take medicines, get the mail, or take a walk. Make a mark that corresponds to your pain level at these times. For example, if you wake at 7 am and your pain is a 6, mark where 7 am and 6 on the pain scale intersect.

The second section, the **Daily Pain Log**, is where you can record information about your pain—intermittent, persistent, or breakthrough—treatments, and side effects. Also record days you have no pain. In addition, use this section to look at how you are dealing and coping with pain. What has helped you most? What is not working? Make additional notes in this section to record pain producing activities, as well as times of pain relief. Also keep a record of things you did to relieve your pain. **You can draw lines from the events on the Chart to explanations in the Log to show why pain levels went up or down.**

Then, at the end of the day, come back and use the **Daily Pain Summary** to give an overview of your pain for that day.

Using all sections gives your medical team the best description of how your pain changes throughout the day. If it's easier for you to complete one part only, that's okay. The important thing is to track your pain each day.

If you are not able to complete a page every day, find someone to help you with the task for at least one week. This can still give your medical team an idea of changes in your pain over time.

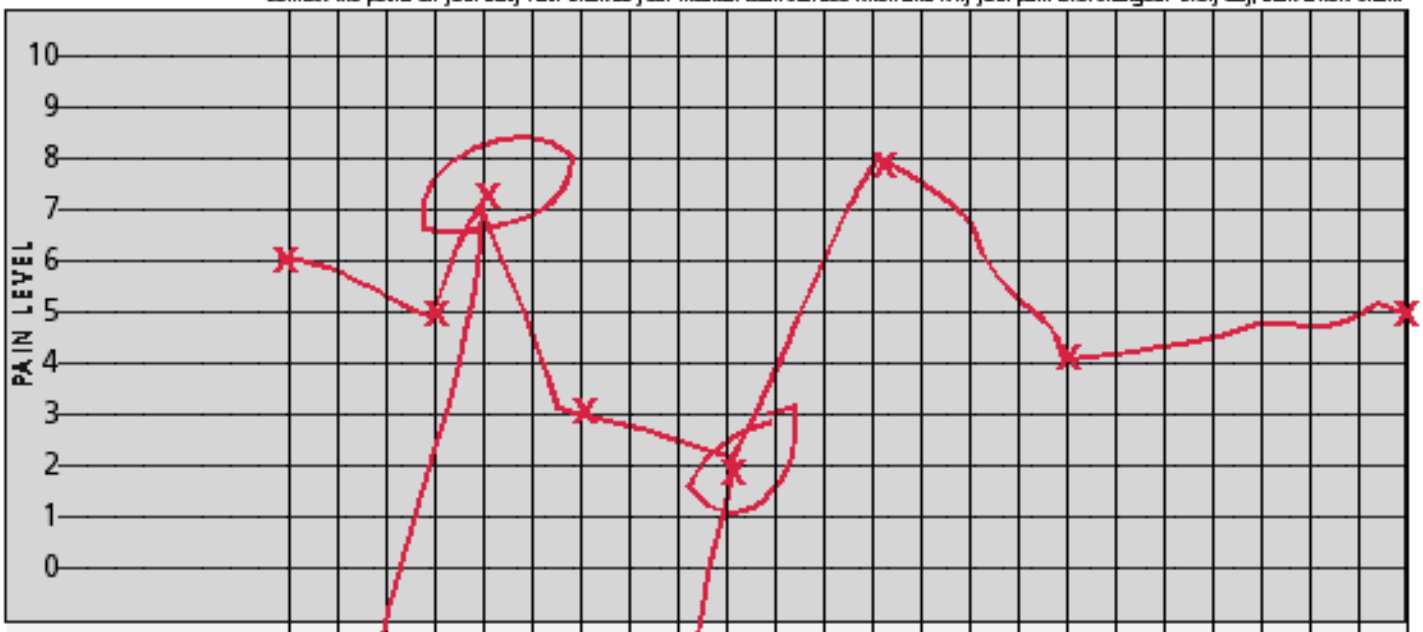
Name Mary Johnson

Day Thursday

Date June 10, 2004

1 DAILY PAIN CHART

Connect the points on your Daily Pain Chart so your medical team can see when and why your pain level changed. Every day, start a new chart.



2 DAILY PAIN LOG

MEDICINES: NAME/DOSE	6am	7	8	9	10	11	12pm	1	2	3	4	5	6pm	7	8	9	10	11	12am	1	2	3	4	5
#1 Morphine long-acting 30 mg 6am and 30mg 6pm													X											
#2 Morphine 10 mg every 9hrs as needed						X																		
#3 Laxative/stool softener 2 every night																								
#4 nausea medicine 1 every 6 hours if needed																								
#5																								

NON-MEDICINE THERAPY (other than prescription medicines)

hot bath

ACTIVITIES/EXERCISE

walked dog

COMMENTS AND MORE INFORMATION: Make notes for and about visits with your healthcare provider, side effects from treatments you may be experiencing, and any problems you are having coping with your pain. You may also want to write more about some of your answers on the previous page.

I forgot my morning medicine. I did a little too much yesterday and had to take it easy today. I felt a little sad today, but was able to reach a friend to talk. My pain is pretty well under control, but I need help with my breakthrough pain.

Name Mary Johnson
Day Thursday
Date June 10, 2004

3 DAILY PAIN SUMMARY

Did you have pain today? ____NO __X__YES

Did you avoid or limit any of your activities or cancel plans today because of pain or changes in your pain?

__X__NO ____YES: **What activities?**

Did you take all your pain medicine today according to instructions? __X__NO ____YES

Even though you took your pain medicine for persistent pain on schedule, were there times during the day that you experienced unrelieved breakthrough pain? ____NO __X__YES

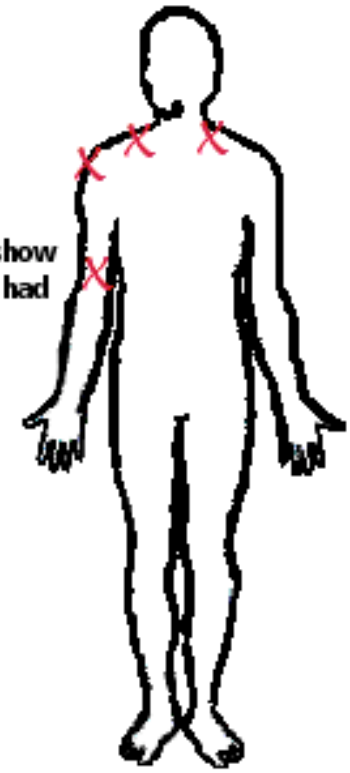
How many times did this happen today?

1 (2) 3 4 5 6 7 8 9 10 more than 10

Did any specific activity start your breakthrough pain? ____NO __X__YES: **What activities?**

walking my dog

Put an "X" on the body diagram to show each place you've had pain today.



What was your average level of pain today?

0 1 2 (3) 4 5 6 7 8 9 10

Other than prescription medicine, did you do anything else today to relieve the pain?
____NO __X__YES (**Check any that you used.**)

__X__ Non-prescription drugs (e.g., acetaminophen, ibuprofen)
____ Herbal remedies
__X__ Hot or cold packs
____ Exercise
____ Changing position (such as lying down or elevating your legs)
____ Physical therapy
____ Massage
____ Acupuncture
____ Rest
____ Psychological counseling
____ Talk to trusted friend, family, clergy
____ Prayer, meditation, guided imagery
____ Relaxation technique (hypnosis, biofeedback)
____ Creative technique (art or music therapy)
__X__ Other (describe):
took a hot bath

Check any of these common side effects that you've noticed after taking your pain medicine.

__X__ Drowsiness, sleepiness
____ Nausea, vomiting, upset stomach
____ Constipation
____ Lack of appetite
____ Other (describe):

Did you skip any of your scheduled pain medicines today? ____NO __X__YES: **Why?**

I forgot

Did you call your doctor's office or clinic between visits because of pain? __X__NO ____YES

Overall, are you satisfied with your pain management? __X__YES ____NO (**Explain what makes you satisfied or not satisfied. Use Log section.**)

What pain level overall would you find acceptable?

0 1 (2) 3 4 5 6 7 8 9 10

Name _____

Day _____

Date _____

1 DAILY PAIN CHART

Connect the points on your Daily Pain Chart so your medical team can see when and why your pain level changed. Every day, start a new chart.

PAIN LEVEL: 10, 9, 8, 7, 6, 5, 4, 3, 2, 1, 0

2 DAILY PAIN LOG

6am, 7, 8, 9, 10, 11, 12pm, 1, 2, 3, 4, 5, 6pm, 7, 8, 9, 10, 11, 12am, 1, 2, 3, 4, 5

MEDICINES: NAME/DOSE

#1 _____

#2 _____

#3 _____

#4 _____

#5 _____

NON-MEDICINE THERAPY (other than prescription medicines)

ACTIVITIES/EXERCISE

COMMENTS AND MORE INFORMATION: Make notes for and about visits with your healthcare provider, side effects from treatments you may be experiencing, and any problems you are having coping with your pain. You may also want to write more about some of your answers on the previous page.

Name _____

Day _____

Date _____

3 DAILY PAIN SUMMARY

Did you have pain today? ____NO ____YES

Did you avoid or limit any of your activities or cancel plans today because of pain or changes in your pain?

____NO ____YES: **What activities?**

_____

Did you take all your pain medicine today according to instructions? ____NO ____YES

Even though you took your pain medicine for persistent pain on schedule , were there times during the day that you experienced unrelieved breakthrough pain? ____NO ____YES

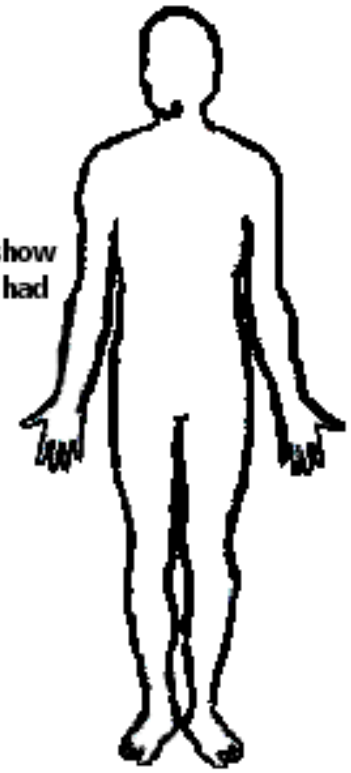
How many times did this happen today?

1 2 3 4 5 6 7 8 9 10 more than 10

Did any specific activity start your breakthrough pain? ____NO ____YES: **What activities?**

_____

Put an "X" on the body diagram to show each place you've had pain today.



What was your average level of pain today?

0 1 2 3 4 5 6 7 8 9 10

Other than prescription medicine, did you do anything else today to relieve the pain?
____NO ____YES (**Check any that you used.**)

____ Non-prescription drugs (e.g., acetaminophen, ibuprofen)
____ Herbal remedies
____ Hot or cold packs
____ Exercise
____ Changing position (such as lying down or elevating your legs)
____ Physical therapy
____ Massage
____ Acupuncture
____ Rest
____ Psychological counseling
____ Talk to trusted friend, family, clergy
____ Prayer, meditation, guided imagery
____ Relaxation technique (hypnosis, biofeedback)
____ Creative technique (art or music therapy)
____ Other (describe):

_____

Check any of these common side effects that you've noticed after taking your pain medicine.

____ Drowsiness, sleepiness
____ Nausea, vomiting, upset stomach
____ Constipation
____ Lack of appetite
____ Other (describe):

_____

Did you skip any of your scheduled pain medicines today? ____NO ____YES: **Why?**

_____

Did you call your doctor's office or clinic between visits because of pain? ____NO ____YES

Overall, are you satisfied with your pain management? ____YES ____NO (**Explain what makes you satisfied or not satisfied. Use Log section.**)

What pain level overall would you find acceptable?

0 1 2 3 4 5 6 7 8 9 10

Name _____

Day _____

Date _____

1 DAILY PAIN CHART

Connect the points on your Daily Pain Chart so your medical team can see when and why your pain level changed. Every day, start a new chart.

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2 DAILY PAIN LOG

MEDICINES: NAME/DOSE

#1

#2

#3

#4

#5

NON-MEDICINE THERAPY (other than prescription medicines)

ACTIVITIES/EXERCISE

COMMENTS AND MORE INFORMATION: Make notes for and about visits with your healthcare provider, side effects from treatments you may be experiencing, and any problems you are having coping with your pain. You may also want to write more about some of your answers on the previous page.

Name _____

Day _____

Date _____

3 DAILY PAIN SUMMARY

Did you have pain today? ____NO ____YES

Did you avoid or limit any of your activities or cancel plans today because of pain or changes in your pain?

____NO ____YES: **What activities?**

_____

Did you take all your pain medicine today according to instructions? ____NO ____YES

Even though you took your pain medicine for persistent pain on schedule , were there times during the day that you experienced unrelieved breakthrough pain? ____NO ____YES

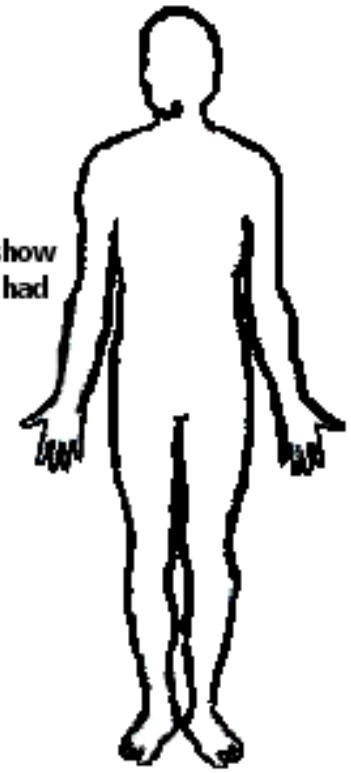
How many times did this happen today?

1 2 3 4 5 6 7 8 9 10 more than 10

Did any specific activity start your breakthrough pain? ____NO ____YES: **What activities?**

_____

Put an "X" on the body diagram to show each place you've had pain today.



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____ Prayer, meditation, guided imagery
____ Relaxation technique (hypnosis, biofeedback)
____ Creative technique (art or music therapy)
____ Other (describe):

_____

Check any of these common side effects that you've noticed after taking your pain medicine.

____ Drowsiness, sleepiness
____ Nausea, vomiting, upset stomach
____ Constipation
____ Lack of appetite
____ Other (describe):

_____

Did you skip any of your scheduled pain medicines today? ____NO ____YES: **Why?**

_____

Did you call your doctor's office or clinic between visits because of pain? ____NO ____YES

Overall, are you satisfied with your pain management? ____YES ____NO (**Explain what makes you satisfied or not satisfied. Use Log section.**)

What pain level overall would you find acceptable?

0 1 2 3 4 5 6 7 8 9 10

Name _____

Day _____

Date _____

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MEDICINES: NAME/DOSE

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#2

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#4

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NON-MEDICINE THERAPY (other than prescription medicines)

ACTIVITIES/EXERCISE

COMMENTS AND MORE INFORMATION: Make notes for and about visits with your healthcare provider, side effects from treatments you may be experiencing, and any problems you are having coping with your pain. You may also want to write more about some of your answers on the previous page.

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Day _____

Date _____

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____NO ____YES: **What activities?**

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Even though you took your pain medicine for persistent pain on schedule , were there times during the day that you experienced unrelieved breakthrough pain? ____NO ____YES

How many times did this happen today?

1 2 3 4 5 6 7 8 9 10 more than 10

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_____

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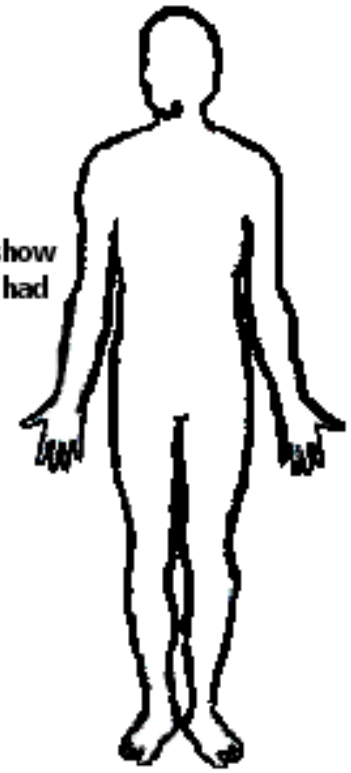

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____ Other (describe):

_____

Check any of these common side effects that you've noticed after taking your pain medicine.

____ Drowsiness, sleepiness
____ Nausea, vomiting, upset stomach
____ Constipation
____ Lack of appetite
____ Other (describe):

_____

Did you skip any of your scheduled pain medicines today? ____NO ____YES: **Why?**

_____

Did you call your doctor's office or clinic between visits because of pain? ____NO ____YES

Overall, are you satisfied with your pain management? ____YES ____NO (**Explain what makes you satisfied or not satisfied. Use Log section.**)

What pain level overall would you find acceptable?

0 1 2 3 4 5 6 7 8 9 10

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MEDICINES: NAME/DOSE

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#3

#4

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ACTIVITIES/EXERCISE

COMMENTS AND MORE INFORMATION: Make notes for and about visits with your healthcare provider, side effects from treatments you may be experiencing, and any problems you are having coping with your pain. You may also want to write more about some of your answers on the previous page.

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Day _____

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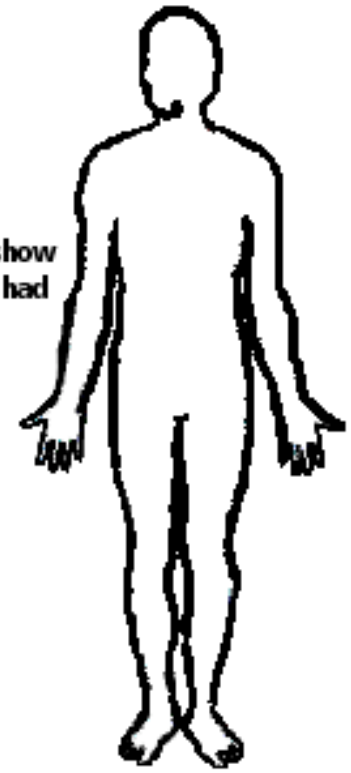

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____ Other (describe):

_____

Check any of these common side effects that you've noticed after taking your pain medicine.

____ Drowsiness, sleepiness
____ Nausea, vomiting, upset stomach
____ Constipation
____ Lack of appetite
____ Other (describe):

_____

Did you skip any of your scheduled pain medicines today? ____NO ____YES: **Why?**

_____

Did you call your doctor's office or clinic between visits because of pain? ____NO ____YES

Overall, are you satisfied with your pain management? ____YES ____NO (**Explain what makes you satisfied or not satisfied. Use Log section.**)

What pain level overall would you find acceptable?

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MEDICINES: NAME/DOSE

#1 _____

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NON-MEDICINE THERAPY (other than prescription medicines)

ACTIVITIES/EXERCISE

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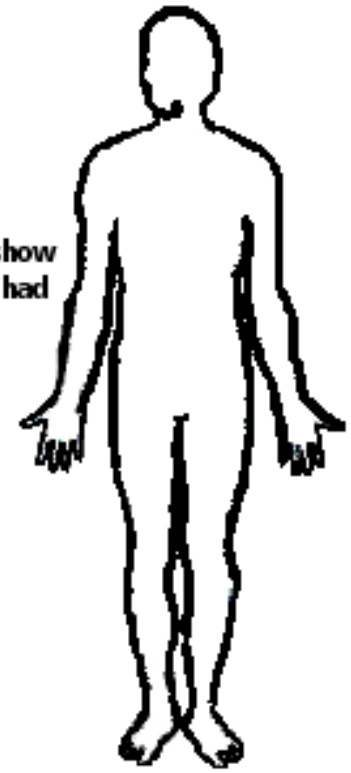

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____ Other (describe):

_____

Check any of these common side effects that you've noticed after taking your pain medicine.

____ Drowsiness, sleepiness
____ Nausea, vomiting, upset stomach
____ Constipation
____ Lack of appetite
____ Other (describe):

_____

Did you skip any of your scheduled pain medicines today? ____NO ____YES: **Why?**

_____

Did you call your doctor's office or clinic between visits because of pain? ____NO ____YES

Overall, are you satisfied with your pain management? ____YES ____NO (**Explain what makes you satisfied or not satisfied. Use Log section.**)

What pain level overall would you find acceptable?

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Name _____

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MEDICINES: NAME/DOSE

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Name _____

Day _____

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3 DAILY PAIN SUMMARY

Did you have pain today? ____NO ____YES

Did you avoid or limit any of your activities or cancel plans today because of pain or changes in your pain?

____NO ____YES: **What activities?**

_____

Did you take all your pain medicine today according to instructions? ____NO ____YES

Even though you took your pain medicine for persistent pain on schedule , were there times during the day that you experienced unrelieved breakthrough pain? ____NO ____YES

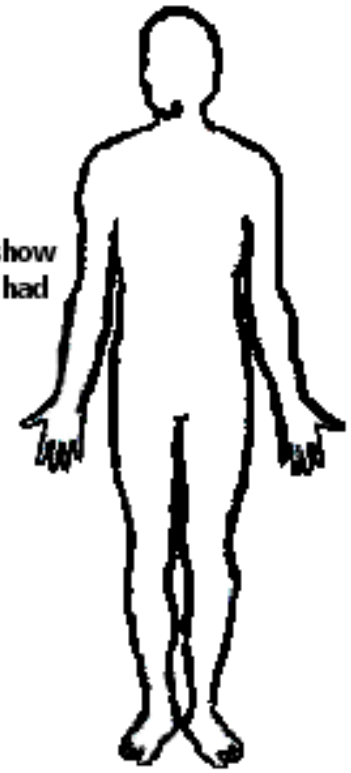
How many times did this happen today?

1 2 3 4 5 6 7 8 9 10 more than 10

Did any specific activity start your breakthrough pain? ____NO ____YES: **What activities?**

_____

Put an "X" on the body diagram to show each place you've had pain today.



What was your average level of pain today?

0 1 2 3 4 5 6 7 8 9 10

Other than prescription medicine, did you do anything else today to relieve the pain?
____NO ____YES (**Check any that you used.**)

____ Non-prescription drugs (e.g., acetaminophen, ibuprofen)
____ Herbal remedies
____ Hot or cold packs
____ Exercise
____ Changing position (such as lying down or elevating your legs)
____ Physical therapy
____ Massage
____ Acupuncture
____ Rest
____ Psychological counseling
____ Talk to trusted friend, family, clergy
____ Prayer, meditation, guided imagery
____ Relaxation technique (hypnosis, biofeedback)
____ Creative technique (art or music therapy)
____ Other (describe):

_____

Check any of these common side effects that you've noticed after taking your pain medicine.

____ Drowsiness, sleepiness
____ Nausea, vomiting, upset stomach
____ Constipation
____ Lack of appetite
____ Other (describe):

_____

Did you skip any of your scheduled pain medicines today? ____NO ____YES: **Why?**

_____

Did you call your doctor's office or clinic between visits because of pain? ____NO ____YES

Overall, are you satisfied with your pain management? ____YES ____NO (**Explain what makes you satisfied or not satisfied. Use Log section.**)

What pain level overall would you find acceptable?

0 1 2 3 4 5 6 7 8 9 10

Name _____

Day _____

Date _____

1 DAILY PAIN CHART

Connect the points on your Daily Pain Chart so your medical team can see when and why your pain level changed. Every day, start a new chart.

PAIN LEVEL: 10, 9, 8, 7, 6, 5, 4, 3, 2, 1, 0

2 DAILY PAIN LOG

6am, 7, 8, 9, 10, 11, 12pm, 1, 2, 3, 4, 5, 6pm, 7, 8, 9, 10, 11, 12am, 1, 2, 3, 4, 5

MEDICINES: NAME/DOSE

#1

#2

#3

#4

#5

NON-MEDICINE THERAPY (other than prescription medicines)

ACTIVITIES/EXERCISE

COMMENTS AND MORE INFORMATION: Make notes for and about visits with your healthcare provider, side effects from treatments you may be experiencing, and any problems you are having coping with your pain. You may also want to write more about some of your answers on the previous page.

Name _____

Day _____

Date _____

3 DAILY PAIN SUMMARY

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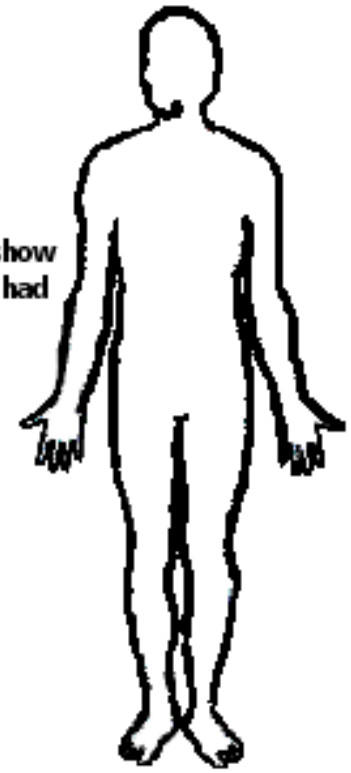

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Overall, are you satisfied with your pain management? ____YES ____NO (**Explain what makes you satisfied or not satisfied. Use Log section.**)

What pain level overall would you find acceptable?

0 1 2 3 4 5 6 7 8 9 10

Notes

Learn More About Pain Relief

- American Pain Foundation (useful information and links to disease-specific information)
  www.painfoundation.org 888-615-PAIN
- American Academy of Pain Medicine
  www.painmed.org 847-375-4731
- American Academy of Pain Management
  www.aapainmanage.org 209-533-9744
- American Alliance of Cancer Pain Initiatives (find listings of state initiatives)
  www.aacpi.wisc.edu 608-265-4013
- American Board of Pain Medicine
  www.abpm.org 847-375-4726
- American Chronic Pain Association
  www.theacpa.org 800-533-3231
- American Pain Society
  www.ampainsoc.org 847-375-4715
- American Society of Pain Management Nursing
  www.aspmn.org 888-342-7766
- Cancer Care
  www.cancercare.org 800-813-4673
- Case Management Resource Guide
  www.cmrg.com 800-784-2332
- Commission on Accreditation of Rehabilitation Facilities
  www.carf.org 520-325-1044
- Mayo Clinic Pain Management Center
  www.mayoclinic.com/findinformation/diseasesandconditions/index.cfm
- National Cancer Institute
  www.nci.nih.gov/cancerinfo 800-422-6237
- National Chronic Pain Society
  www.ncps-cpr.org 281-357-4673
- National Hospice and Palliative Care Organization
  www.nhpco.org 703-837-1500
- National Pain Foundation
  www.nationalpainfoundation.org 303-756-0889
- Pain.com
  www.pain.com

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Feedback!

We welcome your feedback on the Pain Notebook. Is it easy to use? Is it useful? Please send comments and suggestions to: painnotebook@painfoundation.org

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