

DETAILED PAIN DIARY

These diagnostic blocks have been performed to try to isolate and confirm the site of your pain. Please be sure to complete this pain diary as accurately as possible. This is an important part of your assessment and will help with treatment planning decisions. You may 1) bring this form to your next appointment if you are already scheduled for one, 2) fax this when complete to 757-422-4563 (no coversheet needed) or 3) mail to:

5 DA 'Gd]bY'UbX'Gdcflg'D\ ng]V]Ubg#DfcWIXi fYFcca '))'@k YfmFcUX' BcfZ' _zJ]f[]b]U&') \$&**

Patient: _____ Date: _____

Procedure: _____ Dr. _____

Please rate your pain on a scale of 0 (no pain) to 10 (worst pain possible):

Pre-Injection Pain Score (*What was your pain level prior to your injection?*)

	0	1	2	3	4	5	6	7	8	9	10
30 minutes	0	1	2	3	4	5	6	7	8	9	10
TIME: _____											
1 Hour	0	1	2	3	4	5	6	7	8	9	10
TIME: _____											
2 Hours	0	1	2	3	4	5	6	7	8	9	10
TIME: _____											
3 hours	0	1	2	3	4	5	6	7	8	9	10
TIME: _____											
4 hours	0	1	2	3	4	5	6	7	8	9	10
TIME: _____											
5 hours	0	1	2	3	4	5	6	7	8	9	10
TIME: _____											
6 hours	0	1	2	3	4	5	6	7	8	9	10
TIME: _____											
7 hours	0	1	2	3	4	5	6	7	8	9	10
TIME: _____											
8 hours	0	1	2	3	4	5	6	7	8	9	10
TIME: _____											

Long term pain journal: *D`YUgYfUH'nci f`dU]b'cb'h YW UfhVYck 'YUM' XUm* Circle whether your pain is better, the same or worse. In the space provided, you may write a description of your pain (i.e. radiating to leg, soreness, etc.) and any medications that you have taken to help reduce the pain.

Date: _____ BETTER SAME WORSE _____

Date: _____ BETTER SAME WORSE _____

Date: _____ BETTER SAME WORSE _____

Date: _____ BETTER SAME WORSE _____

Date: _____ BETTER SAME WORSE _____