

Patient Name: _____

Date of Birth: _____

Physician Name: _____

Procedure: _____

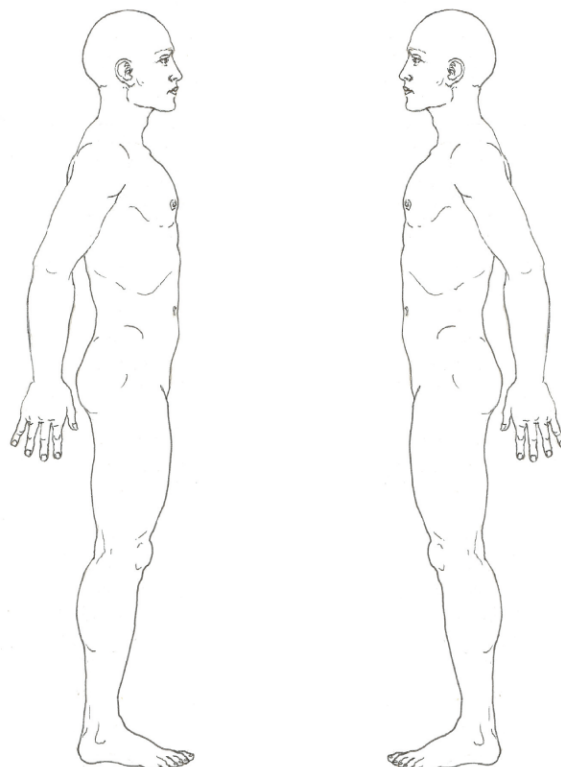
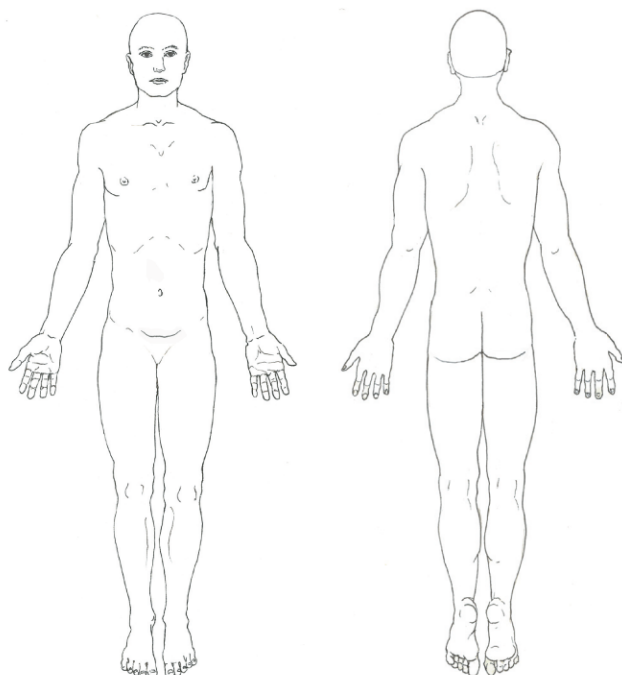
Procedure Date: _____

Procedure Time: _____

Pain Level (Circle) on a 0-10 scale. 0 being no pain.
10 being severe pain that would send you to the emergency room.

Prior to procedure	A	0	1	2	3	4	5	6	7	8	9	10
	B	0	1	2	3	4	5	6	7	8	9	10
	C	0	1	2	3	4	5	6	7	8	9	10
	D	0	1	2	3	4	5	6	7	8	9	10
30 minutes after	A	0	1	2	3	4	5	6	7	8	9	10
	B	0	1	2	3	4	5	6	7	8	9	10
	C	0	1	2	3	4	5	6	7	8	9	10
	D	0	1	2	3	4	5	6	7	8	9	10
1 hour after	A	0	1	2	3	4	5	6	7	8	9	10
	B	0	1	2	3	4	5	6	7	8	9	10
	C	0	1	2	3	4	5	6	7	8	9	10
	D	0	1	2	3	4	5	6	7	8	9	10
4 hours after	A	0	1	2	3	4	5	6	7	8	9	10
	B	0	1	2	3	4	5	6	7	8	9	10
	C	0	1	2	3	4	5	6	7	8	9	10
	D	0	1	2	3	4	5	6	7	8	9	10
1 day after	A	0	1	2	3	4	5	6	7	8	9	10
	B	0	1	2	3	4	5	6	7	8	9	10
	C	0	1	2	3	4	5	6	7	8	9	10
	D	0	1	2	3	4	5	6	7	8	9	10
2 days after	A	0	1	2	3	4	5	6	7	8	9	10
	B	0	1	2	3	4	5	6	7	8	9	10
	C	0	1	2	3	4	5	6	7	8	9	10
	D	0	1	2	3	4	5	6	7	8	9	10
1 week after	A	0	1	2	3	4	5	6	7	8	9	10
	B	0	1	2	3	4	5	6	7	8	9	10
	C	0	1	2	3	4	5	6	7	8	9	10
	D	0	1	2	3	4	5	6	7	8	9	10

Draw all your areas of pain that your physician is performing the injection for. Label A, B, C, D.



Right

Left