



After completing this diary A B C

please fax: 905-886-0248

POST PROCEDURE PAIN DIARY

PATIENT IDENTIFICATION

Procedure: _____

Procedure date: / /
 YYYY / MM / DD

Physician: _____

You have undergone a procedure (nerve block) to reduce your pain. We would like to know your progress following the procedure. On a scale of 0 to 10 (**0- no pain, 10- the worst pain that you can imagine**), kindly give a score (please encircle) to your pain levels at following times:

Pre-procedure pain score 0 1 2 3 4 5 6 7 8 9 10
(to be filled by nurse at time of admission)

A

Post-procedure pain scores:

On the day of procedure:

Immediately after the procedure	0	1	2	3	4	5	6	7	8	9	10
30 minutes after the procedure	0	1	2	3	4	5	6	7	8	9	10
1 hour after the procedure	0	1	2	3	4	5	6	7	8	9	10
2 hours after the procedure	0	1	2	3	4	5	6	7	8	9	10
3 hours after the procedure	0	1	2	3	4	5	6	7	8	9	10
4 hours after the procedure	0	1	2	3	4	5	6	7	8	9	10
5 hours after the procedure	0	1	2	3	4	5	6	7	8	9	10
6 hours after the procedure	0	1	2	3	4	5	6	7	8	9	10

On a scale of 0-100% , overall I feel _____ % better /worse (circle one)

This form MUST BE returned to your pain physician for assessment prior to your follow up appointment. You have 2 options to do this:

1. Fax the Pain Diary to your physician to the Pain Clinic at 905-886-0248
2. Mail a copy of the Pain Diary to the clinic

Please bring the original Pain Diary with you when you come for your follow-up appointment in the Pain Clinic or for your next procedure.