APM
SPINE & SPORTS PHYSICIANS
Reducing Pain - Restoring Function

PAIN DIARY FOR SPINAL INJECTIONS

Please complete the form below at the designated times. It Is based on a scale of 0 (no pain) to 10 (worst imaginable pain). This information is very helpful in determining the source of your pain. Please be sure to complete this pain diary as accurately as possible. 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:

APM Spine and Sports Physicians/Procedure Room
5665 Lowery Road
Norfolk, Virginia 23502

Patient: _____ Date: _____

Procedure: _____ Dr. _____

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

Pain rating before the injection: **Time** _____ **Area:** _____

0 1 2 3 4 5 6 7 8 9 10

30 minutes after injection: **Time:** _____

0 1 2 3 4 5 6 7 8 9 10

1 hour after: **Time:** _____

0 1 2 3 4 5 6 7 8 9 10

3 hours after: **Time:** _____

0 1 2 3 4 5 6 7 8 9 10

12 hours after: **Time:** _____

0 1 2 3 4 5 6 7 8 9 10

1 day after: **Time:** _____

0 1 2 3 4 5 6 7 8 9 10

3 days after: **Time:** _____

0 1 2 3 4 5 6 7 8 9 10

7 days after: **Time:** _____

0 1 2 3 4 5 6 7 8 9 10

10 days after: **Time:** _____

0 1 2 3 4 5 6 7 8 9 10

14 days after: **Time:** _____

0 1 2 3 4 5 6 7 8 9 10