

Daily Pain Log

Patient: _____ **MR#:** _____

Referring Physician: _____

You have just had an injection with anesthetic solution, steroid or a combination of the two for the purposes of pain relief and localization. Please take this sheet with you and use it to record any changes in your symptoms. This Information may have important diagnostic and therapeutic implications for your treatment. If utilized for research purposes, strict confidentiality will be maintained. Please send it back to Hospital for Special Surgery in the self-addressed, stamped envelope provided or fax it to the number at the bottom of this page.

Thank You.

Procedure: _____ **Date:** _____

Discharge Time: _____ **Radiologist:** _____

Day	Day of the Week	Date	Time	Pain Scale									
				No Pain ←			Pain				→ Worst Typical		
#1			Immediately Pre Injection	1	2	3	4	5	6	7	8	9	10
#1			Immediately Post Injection	1	2	3	4	5	6	7	8	9	10
#1			2 Hours Post Injection	1	2	3	4	5	6	7	8	9	10
#1			4 Hours Post Injection	1	2	3	4	5	6	7	8	9	10
#1			8 Hours Post Injection	1	2	3	4	5	6	7	8	9	10
#2			AM	1	2	3	4	5	6	7	8	9	10
#2			PM	1	2	3	4	5	6	7	8	9	10
#3			AM	1	2	3	4	5	6	7	8	9	10
#3			PM	1	2	3	4	5	6	7	8	9	10
#4			AM	1	2	3	4	5	6	7	8	9	10
#4			PM	1	2	3	4	5	6	7	8	9	10
#5			AM	1	2	3	4	5	6	7	8	9	10
#5			PM	1	2	3	4	5	6	7	8	9	10
#6			AM	1	2	3	4	5	6	7	8	9	10
#6			PM	1	2	3	4	5	6	7	8	9	10
#7			AM	1	2	3	4	5	6	7	8	9	10
#7			PM	1	2	3	4	5	6	7	8	9	10