

# Pain Diary

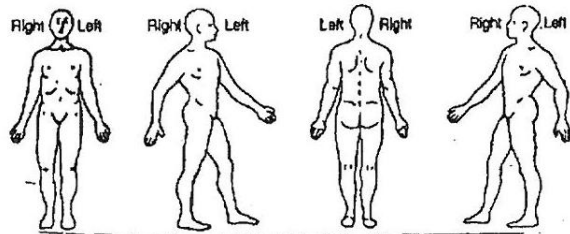
**Please bring this sheet with you to your next appointment.**

Procedure: \_\_\_\_\_

Main Pain Area: \_\_\_\_\_

Concurrent Pain: \_\_\_\_\_

Main Pain Area Pre-Injection: \_\_\_\_\_



List 4 activities limited by pain (ex. bending, lifting, sitting, walking, turning)	Percentage improvement in each activity after injection					
	1 hr	2 hrs	4 hrs	6 hrs	12 hrs	24 hrs
Ignore any new discomfort from injection						
1.						
2.						
3.						
4.						

**Please circle the number that best describes the pain for which you had the injection**

<b>Pre-Injection</b>	1	2	3	4	5	6	7	8	9	10	Worst Pain
No Pain											
<b>At 1 hour:</b>	1	2	3	4	5	6	7	8	9	10	Worst Pain
No Pain											
<b>At 2 hrs:</b>	1	2	3	4	5	6	7	8	9	10	Worst Pain
No Pain											

<b>At 4 hrs:</b>	1	2	3	4	5	6	7	8	9	10	Worst
No Pain											Pain
<b>At 6 hrs:</b>	1	2	3	4	5	6	7	8	9	10	Worst
No Pain											Pain
<b>At 12 hrs:</b>	1	2	3	4	5	6	7	8	9	10	Worst
No Pain											Pain
<b>At 24 hrs:</b>	1	2	3	4	5	6	7	8	9	10	Worst
No Pain											Pain

**Regarding your expectations about the injection, was it**  
 better                       worse                       what you expected

**Please increase your activity to evaluate the effectiveness of the block.**

Disclaimer: This document is for informational purposes only and is not intended to take the place of the care and attention of your personal physician or other professional medical services. Talk with your doctor if you have Questions about individual health concerns or specific treatment options.

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