

2 WEEK PAIN DIARY

Email Address: _____

Name: _____

Procedure: _____

Date: _____

Index pain: _____

Comments: _____

X = Index Pain Intensity/Level

Half hour increments after injection

Days after injection

Excruciating	10																			
	9																			
Horrible	8																			
	7																			
Distressing	6																			
	5																			
Discomforting	4																			
	3																			
Mild	2																			
	1																			
No Pain	0																			
		0.0	0.5	1.0	1.5	2.0	2.5	3.0	3.5	4.0	4.5	5.0	5.5	6.0						

10																				
	9																			
8																				
	7																			
6																				
	5																			
4																				
	3																			
2																				
	1																			
0																				
		1	2	3	4	5	6	7	8	9	10	11	12	13	14					

Please answer question #1 **six hours** after your injection:

1. Within the first six hours after the injection(s), what % pain relief did you experience? _____ %

Please answer questions #2 & 3 **fourteen days** after your injection:

2. Two weeks following the injection(s), what % pain relief did you experience? _____ %

3. Circle 1 of the following for each of the questions below:

a. Since the injection(s), your ability to perform day to day activities has:

Dramatically Worse	Somewhat Worse	Not Changed	Somewhat Improved	Dramatically Improved
-----------------------	-------------------	----------------	----------------------	--------------------------

b. Since the injection(s), your intake of medication to control your pain has:

Dramatically Increased	Mildly Increased	Not Changed	Mildly Decreased	Dramatically Decreased
---------------------------	---------------------	----------------	---------------------	---------------------------

Return to: Dr. R. Burnham @ #1, 6220 - Hwy 2A Lacombe T4L 2G5
Phone: (403)782-6555 or Fax: (403)782-6511 email: questionsfordoctor@telus.net