

# Spine Center Pain Diary

Before the procedure, how much pain did you have? (Circle one)

(No Pain)	0	1	2	3	4	5	6	7	8	9	10	(Pain)
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Starting right after your procedure, please record below the amount of pain you have.

Do this every 30 minutes for 4 hours.

Time	Pain Level (Circle one)											Activity (Sitting, walking, etc.)
	No pain						Worst Pain					
	0	1	2	3	4	5	6	7	8	9	10	
	0	1	2	3	4	5	6	7	8	9	10	
	0	1	2	3	4	5	6	7	8	9	10	
	0	1	2	3	4	5	6	7	8	9	10	
	0	1	2	3	4	5	6	7	8	9	10	
	0	1	2	3	4	5	6	7	8	9	10	
	0	1	2	3	4	5	6	7	8	9	10	
	0	1	2	3	4	5	6	7	8	9	10	
	0	1	2	3	4	5	6	7	8	9	10	
	0	1	2	3	4	5	6	7	8	9	10	

After completion of the diary, please:

Fax the results to (781) 251-3755 or scan and email to [NEBHSpineCenter@nebh.org](mailto:NEBHSpineCenter@nebh.org).

For Office Use Only

Procedure _____	Time _____
Numbing agents _____	Steroid agent _____