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)

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) No pain Worst Pain	**Activity (Sitting, walking, etc.)**
	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.

For Office Use Only

Procedure_____ Time_____

Numbing agents_____ Steroid agent_____

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