

Fill out this form starting on the day of injection.
When finished bring it to your next appointment.

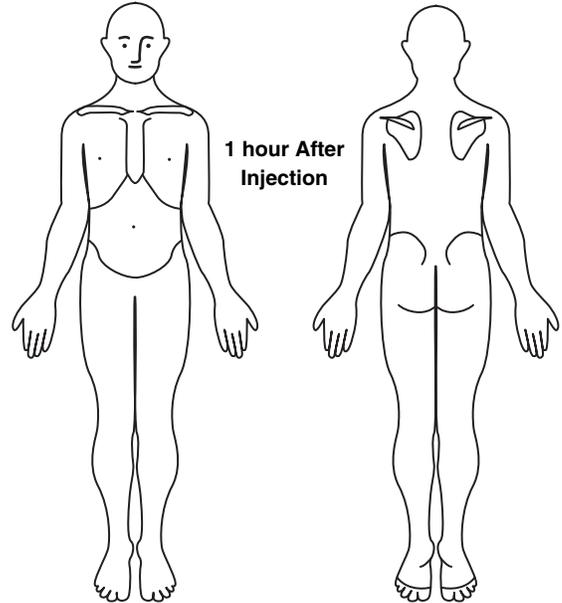
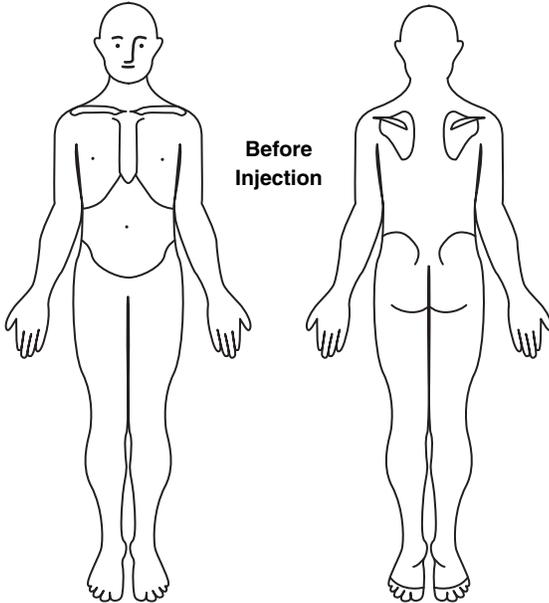
Claim # _____

Name _____

Date _____

Shade in where you have pain before the injection

Shade in where you have pain 1 hour after the injection



Circle the pain level; 10 is the most severe

Circle the pain level; 10 is the most severe

1 2 3 4 5 6 7 8 9 10

1 2 3 4 5 6 7 8 9 10

Time since injection

Pain Level

Date & Time

2 hours after injection 1 2 3 4 5 6 7 8 9 10 _____

3 hours after injection 1 2 3 4 5 6 7 8 9 10 _____

4 hours after injection 1 2 3 4 5 6 7 8 9 10 _____

5 hours after injection 1 2 3 4 5 6 7 8 9 10 _____

6 hours after injection 1 2 3 4 5 6 7 8 9 10 _____

7 hours after injection 1 2 3 4 5 6 7 8 9 10 _____

8 hours after injection 1 2 3 4 5 6 7 8 9 10 _____

1 day after injection 1 2 3 4 5 6 7 8 9 10 _____

2 days after injection 1 2 3 4 5 6 7 8 9 10 _____

Turn Page Over for Days 3- 14

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Claim # _____

Name _____

Date _____

Time since injection.	Pain Level										Date & Time
3 days after injection	1	2	3	4	5	6	7	8	9	10	_____
4 days after injection	1	2	3	4	5	6	7	8	9	10	_____
5 days after injection	1	2	3	4	5	6	7	8	9	10	_____
6 days after injection	1	2	3	4	5	6	7	8	9	10	_____
7 days after injection	1	2	3	4	5	6	7	8	9	10	_____
8 days after injection	1	2	3	4	5	6	7	8	9	10	_____
9 days after injection	1	2	3	4	5	6	7	8	9	10	_____
10 days after injection	1	2	3	4	5	6	7	8	9	10	_____
11 days after injection	1	2	3	4	5	6	7	8	9	10	_____
12 days after injection	1	2	3	4	5	6	7	8	9	10	_____
13 days after injection	1	2	3	4	5	6	7	8	9	10	_____
14 days after injection	1	2	3	4	5	6	7	8	9	10	_____

Is there anything you can do now that you could not do prior to the injection? Please jot it down.

For the Doctor. List of structures injected.

PAIN DRAWING

Name: _____ Today's Date: _____

Date of Birth: _____ Examiner: _____

Claim # _____

Tell Us Where You Hurt.

Please read carefully:

Mark the areas on your body where you feel your pain using the symbols as shown below. Include all affected areas. Mark areas of radiation. If your pain radiates, draw an arrow from where it starts to where it stops. Please extend the arrow as far as the pain travels.

Ache >>>>
>>>>

Numbness ----

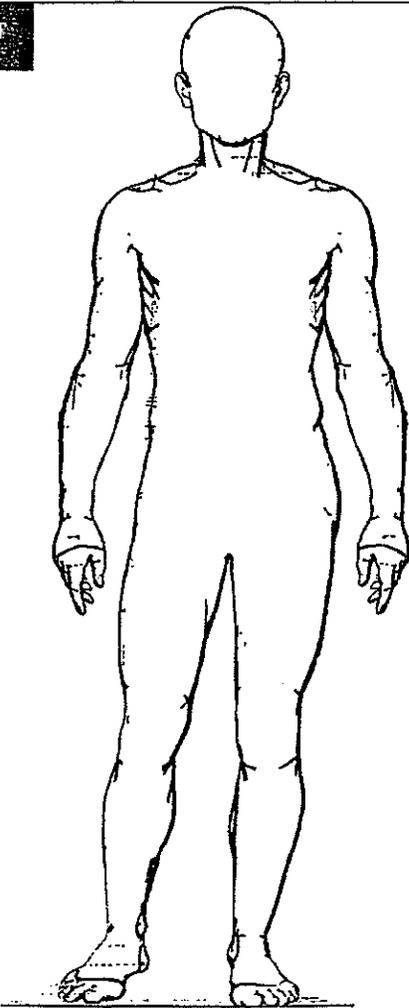
Pins and Needles oooo
oooo

Burning x x x x
x x x x

Stabbing ////
////

Throbbing ~~~~
~~~~

**FRONT**



**BACK**

