CRYSTAL COAST PAIN MANAGEMENT CENTER

Fax to: Morehead City 252-726-8638, New Bern 252-636-0335, Jacksonville 910-353-6009
or ***return to office one week after injection***

Post-Procedure Pain Assessment

Name: _____ **DOB:** _____ **Date:** _____

Procedure: _____

Provider: ☐ Harum ☐ Tellis ☐ Kitchen ☐ McCutcheon ☐ Auman

Pre-Procedure Pain Level: 1 2 3 4 5 6 7 8 9 10 Comments: _____

Post-Procedure Pain Level: 1 2 3 4 5 6 7 8 9 10 Comments: _____

Track your pain on a scale of 0-10, three times per day: 0 = no pain; 10 = the worst pain imaginable

# Day Post Procedure	Morning Pain Level #	Afternoon Pain Level #	Evening Pain Level #
Day 1			
Day 2			
Day 3			
Day 4			
Day 5			
Day 6			

1. Were activities limited or hard to complete prior to receiving this procedure? YES NO
2. Have these activities improved since receiving this procedure? YES NO
3. Did your sleep improve after receiving this procedure? YES NO
4. What activities are you able to do now that you have not been able to do before this procedure?

_____

5. ***What percentage of pain relief did you get from this procedure: _____ %***