

Surgery Center of Pinehurst

Pain Management Pain Diary

Filling out this pain diary will help your physician understand how pain affects your daily activities and /or how much our treatment has helped. This information will help us work out a plan to best control your pain.

How to fill out the diary:

Pain Level: Circle the number that best describes your pain level. Try to focus on the pain that you have with activity. Typically, there will be some soreness caused from having an injection, but we want you to rate your pain with activity. Remember, number one is very little pain and number ten is the worst pain you can imagine.

Medication: Fill in the name and amount of the medication you took at the time noted in the column. Try to avoid taking any pain medication for approximately 6 to 8 hours after the procedure.


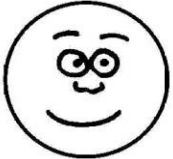
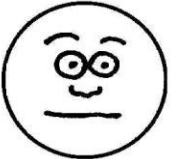


Other pain relief measures: Fill in any measures that you may use to get good control of the pain. This may include rest, use of ice packs, or heat over the painful area.

Activity: We want you to be active after this procedure so that we can best judge what should be done next. Please list the activities that you do during this timeframe, such as: walking, mopping, sweeping, etc. Taking a nap or resting will not give us a clear answer. Complete the diary for the time set by the Pain Management staff.

Remember to send it back to us as soon as possible!

You may mail the diary back to the Surgery Center of Pinehurst-10 First Village Dr. Pinehurst NC 28374. You may also email to 50623pd@scasurgery.com

Thank you!

PAIN LEVEL														
0	1	2	3	4	5	6	7	8	9	10				
NO PAIN		MILD PAIN		MODERATE			SEVERE PAIN			WORST POSSIBLE PAIN				
														
0		1-2		3 - 4			5 - 6			7 - 8			9 - 10	

Date: _____ **Procedure** _____ **# 1 2 (circle) Levels X**

Physical Therapy: Yes No (circle) Name of Facility: _____

How many visits / weeks completed? _____ **Patient Phone #** _____

TIME	PAIN LEVEL CIRCLE THE NUMBER THAT BEST DESCRIBES YOUR PAIN	MEDICATION TAKEN- other pain relief measures	ACTIVITY Example: Lying down, Sitting, Sweeping, Walking, etc.
7 AM	0 1 2 3 4 5 6 7 8 9 10		
7:30 AM	0 1 2 3 4 5 6 7 8 9 10		
8 AM	0 1 2 3 4 5 6 7 8 9 10		
8:30 AM	0 1 2 3 4 5 6 7 8 9 10		
9 AM	0 1 2 3 4 5 6 7 8 9 10		
9:30 AM	0 1 2 3 4 5 6 7 8 9 10		
10 AM	0 1 2 3 4 5 6 7 8 9 10		
10:30 AM	0 1 2 3 4 5 6 7 8 9 10		
11 AM	0 1 2 3 4 5 6 7 8 9 10		
11:30 AM	0 1 2 3 4 5 6 7 8 9 10		
12 PM	0 1 2 3 4 5 6 7 8 9 10		
12:30 PM	0 1 2 3 4 5 6 7 8 9 10		
1 PM	0 1 2 3 4 5 6 7 8 9 10		
1:30 PM	0 1 2 3 4 5 6 7 8 9 10		
2 PM	0 1 2 3 4 5 6 7 8 9 10		
2:30 PM	0 1 2 3 4 5 6 7 8 9 10		
3 PM	0 1 2 3 4 5 6 7 8 9 10		
3:30 PM	0 1 2 3 4 5 6 7 8 9 10		
4 PM	0 1 2 3 4 5 6 7 8 9 10		
4:30 PM	0 1 2 3 4 5 6 7 8 9 10		
5 PM	0 1 2 3 4 5 6 7 8 9 10		
5:30 PM	0 1 2 3 4 5 6 7 8 9 10		
6 PM	0 1 2 3 4 5 6 7 8 9 10		
6:30 PM	0 1 2 3 4 5 6 7 8 9 10		
7 PM	0 1 2 3 4 5 6 7 8 9 10		
7:30 PM	0 1 2 3 4 5 6 7 8 9 10		
8 PM	0 1 2 3 4 5 6 7 8 9 10		
8:30 PM	0 1 2 3 4 5 6 7 8 9 10		
9 PM	0 1 2 3 4 5 6 7 8 9 10		
9:30 PM	0 1 2 3 4 5 6 7 8 9 10		
10 PM	0 1 2 3 4 5 6 7 8 9 10		
10:30 PM	0 1 2 3 4 5 6 7 8 9 10		
11 PM	0 1 2 3 4 5 6 7 8 9 10		

Overall, do you feel like this procedure helped you on the day it was performed? Yes No

Comments: _____