CRYSTAL COAST PAIN MANAGEMENT CENTER

Please Fax to: Morehead City (252-726-8638), New Bern (252-636-0335), Jacksonville (910-353-6009)
or ***return to office within 48 hours***

Pain Scale Log

Patient Name:_____________________________________**DOB:**____________ **Date:**__________________

Beginning Pain Score:______________________ **Location/Description:**_______________________________

Procedure:____**Provider**______________________________

Rate your pain on a 0 to 10 scale every 15 minutes. 0= no pain and 10= worst pain you have ever experienced. Circle appropriate number and place R=Right or L=Left next to number if applicable**.** Use the comments section to add any information that you think may help explain your pain level. This is a ***diagnostic test only, this is not a treatment*****.** The pain will most likely return in about 3-5 hours, as the numbing medicine wears off. **In order to be able to request additional treatments this form must be returned to the office within 48 hours of your procedure. Insurance companies require this documentation in order to authorize the radiofrequency ablation.**

Time	Pain scale 0/10: Circle one											Patient Comments/Notes
:00	0	1	2	3	4	5	6	7	8	9	10	
:15	0	1	2	3	4	5	6	7	8	9	10	
:30	0	1	2	3	4	5	6	7	8	9	10	
:45	0	1	2	3	4	5	6	7	8	9	10	
:00	0	1	2	3	4	5	6	7	8	9	10	
:15	0	1	2	3	4	5	6	7	8	9	10	
:30	0	1	2	3	4	5	6	7	8	9	10	
:45	0	1	2	3	4	5	6	7	8	9	10	
:00	0	1	2	3	4	5	6	7	8	9	10	
:15	0	1	2	3	4	5	6	7	8	9	10	
:30	0	1	2	3	4	5	6	7	8	9	10	
:45	0	1	2	3	4	5	6	7	8	9	10	
:00	0	1	2	3	4	5	6	7	8	9	10	
:15	0	1	2	3	4	5	6	7	8	9	10	
:30	0	1	2	3	4	5	6	7	8	9	10	
:45	0	1	2	3	4	5	6	7	8	9	10	
:00	0	1	2	3	4	5	6	7	8	9	10	
:15	0	1	2	3	4	5	6	7	8	9	10	
:30	0	1	2	3	4	5	6	7	8	9	10	
:45	0	1	2	3	4	5	6	7	8	9	10	
:00	0	1	2	3	4	5	6	7	8	9	10	**Total % of Pain Relief:** **Duration of Pain Relief:**

Prior Facet Block if applicable: Date:_____________ Location:______________________
Total % of Pain Relief & Duration______________________

01/2018