Center for Pain and Headache Medicine

Guardian Medical Care

POST-PROCEDURE PAIN DIARY

INSTRUCTIONS: Please complete this form carefully and bring this form with you to your next appointment or FAX to 912-324-4097. This information will help your physician to assess your response to today's procedure and plan for more treatments.

PATIENT'S NAME: _____ PROCEDURE: _____

DATE OF PROCEDURE: _____ LEVEL OF PAIN (admission): ___ LEVEL OF PAIN (discharge): _____

Use the scale belwo to rate your pain 0 (zero) for no pain and 10 (ten) for the highest level of pain

0	1	2	3	4	5	6	7	8	9	10
No pain	Mild			Moderate			Severe			Worst

Area of pain treated:

☐	Right	☐	Middle	☐	Foot	☐	Hand
☐	Upper	☐	Leg	☐	Head	☐	Shoulder
☐	Hip	☐	Both Sides	☐	Arm	☐	Back
☐	Left	☐	Lower	☐	Neck	☐	Other: _____

Day	On average, rate the level of pain for the day (0-10)	Brief comment on improvement, or other comments
1 – 1st hour		
1 – 2nd hour		
1 – 3rd hour		
1 – 4th hour		
1 – 5th hour		
1 – 6th hour		
1 – 7th hour		
2		
3		
4		
5-7		
8-14		
15-21		
22+		

Center for Pain and Headache Medicine
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