PAIN DIARY

SYNOSIA
BRAIN SPINE NERVES

PATIENT NAME _____ **INJECTION DATE** _____ **DIARY END DATE** _____

Please complete this form immediately prior to your guided injection and once per day for the 7 days following your injection. Please use the space below to note any significant observations. Once completed please return your pain diary to us at reception@synosia.com.au or bring to your next appointment with Dr Lucas.

DATE	TIME Morning / Afternoon / Evening	TYPE OF PAIN Circle one or add your own	PAIN RATING 0 = no pain 10 = worst pain	LOCATION Where is the pain?	EFFECT ON ACTIVITIES What could you not do or do less of?	MEDICATION USE Less / Same / More
PRE-INJECTION	BASELINE	Dull / Sharp / Burning / Tingling / Other	0 1 2 3 4 5 6 7 8 9 10			Less Same More
		Dull / Sharp / Burning / Tingling / Other	0 1 2 3 4 5 6 7 8 9 10			Less Same More
		Dull / Sharp / Burning / Tingling / Other	0 1 2 3 4 5 6 7 8 9 10			Less Same More
		Dull / Sharp / Burning / Tingling / Other	0 1 2 3 4 5 6 7 8 9 10			Less Same More
		Dull / Sharp / Burning / Tingling / Other	0 1 2 3 4 5 6 7 8 9 10			Less Same More
		Dull / Sharp / Burning / Tingling / Other	0 1 2 3 4 5 6 7 8 9 10			Less Same More
		Dull / Sharp / Burning / Tingling / Other	0 1 2 3 4 5 6 7 8 9 10			Less Same More
		Dull / Sharp / Burning / Tingling / Other	0 1 2 3 4 5 6 7 8 9 10			Less Same More

SIGNIFICANT OBSERVATIONS