

## POST INJECTION EVALUATION

The following information needs to be completed and mailed or faxed to our office after 14 days. When rating your pain, concentrate on your regular pain, not soreness from the injection itself.

**0 = no pain                      10 = the worst pain imaginable**

**30 minutes after the procedure, my pain level on a 0-10 scale is:**

**0 0.5 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 5.5 6.0 6.5 7.0 7.5 8.0 8.5 9.0 9.5 10**

**1-hour after the procedure, my pain level on a 0-10 scale is:**

**0 0.5 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 5.5 6.0 6.5 7.0 7.5 8.0 8.5 9.0 9.5 10**

**2-hours after the procedure, my pain level on a 0-10 scale is:**

**0 0.5 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 5.5 6.0 6.5 7.0 7.5 8.0 8.5 9.0 9.5 10**

**3-hours after the procedure, my pain level is on a 0-10 scale is:**

**0 0.5 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 5.5 6.0 6.5 7.0 7.5 8.0 8.5 9.0 9.5 10**

**4-hours after the procedure, my pain level on a 0-10 scale is:**

**0 0.5 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 5.5 6.0 6.5 7.0 7.5 8.0 8.5 9.0 9.5 10**

**5-hours after the procedure, my pain level on a 0-10 scale is:**

**0 0.5 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 5.5 6.0 6.5 7.0 7.5 8.0 8.5 9.0 9.5 10**

**6-hours after the procedure, my pain level on a 0-10 scale is:**

**0 0.5 1.0 1.5 2.0 2.5 3.0 3.5 4.0 4.5 5.0 5.5 6.0 6.5 7.0 7.5 8.0 8.5 9.0 9.5 10**

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**7-days after the procedure, my pain level on a 0-10 scale is:**

<b>0</b>	0.5	<b>1.0</b>	1.5	<b>2.0</b>	2.5	<b>3.0</b>	3.5	<b>4.0</b>	4.5	<b>5.0</b>	5.5	<b>6.0</b>	6.5	<b>7.0</b>	7.5	<b>8.0</b>	8.5	<b>9.0</b>	9.5	<b>10</b>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**14-days after the procedure, my pain level on a 0-10 scale is:**

<b>0</b>	0.5	<b>1.0</b>	1.5	<b>2.0</b>	2.5	<b>3.0</b>	3.5	<b>4.0</b>	4.5	<b>5.0</b>	5.5	<b>6.0</b>	6.5	<b>7.0</b>	7.5	<b>8.0</b>	8.5	<b>9.0</b>	9.5	<b>10</b>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Compared to before the treatment:**

**My pain is:**

- 1. Completely relieved (no pain)
- 2. Markedly improved
- 3. Moderately improved
- 4. Slightly improved
- 5. Unchanged
- 6. Slightly worse
- 7. Moderately worse
- 8. Markedly worse

**My activity level is:**

- 1. Unrestricted (normal)
- 2. Markedly improved
- 3. Moderately improved
- 4. Slightly improved
- 5. Unchanged
- 6. Slightly worse
- 7. Moderately worse
- 8. Markedly worse

**NOTES:**

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**To be filled out by the Physician:**

Procedure 1:    **R**    **L**    **B**   \_\_\_\_\_

Procedure 2:    **R**    **L**    **B**   \_\_\_\_\_