Please submit this form via the Athena Portal or use one of the following methods:

This form is required by insurance for benefit coverage

Fax: 614-956-7011

Text: 614-591-0020

Email: forms@pssmohio.com

PERKINS SPINE SPORTS MEDICINE

PAIN DIARY

Patient Name: _____

Date: _____

Site Description:

A. _____

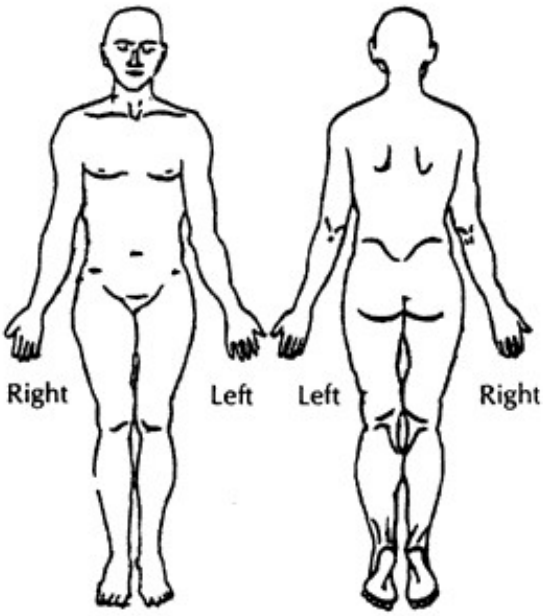
B. _____

C. _____

Time of Procedure: _____AM/PM

Quality of Pain:

- \- Less than typical pain
- = Typical Pain
- \+ Worse than typical pain



Please assess pain level (0-10) and quality (-,=,+) at 15 minute intervals for 2 hours, then for 24 hours (when awake). After 24 hours, only note when there is a change in pain. Use another sheet of paper if necessary.

Time	Pain Site A	Pain Site B	Pain Site C
Pre-procedure:			
Post-Procedure:			

Please bring to your next appointment.

PERKINS
SPINE SPORTS
MEDICINE

Please bring to your next appointment.