Briz Brain & Spine
NEUROSURGERY & SPINAL SURGERY

Self Assessment Form

Degree of pain relief following a nerve block

Please present this assessment form to your referring doctor at your next appointment

Patient Name:_____ D.O.B:_____

Address:_____

Phone:_____ Date:_____

Procedure:_____

Post-Procedure Pain Score

(Please tick applicable boxes)

Worst Pain

10														
9														
8														
7														
6														
5														
4														
3														
2														
1														
0														
	PRE	6PM	8AM	12MD	6PM	8AM	12MD	6PM	8AM	12MD	6PM	8AM	12MD	6PM

Comments:_____

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