

Name: _____

LOG FOR DIAGNOSTIC BLOCK

MRN#: _____

Date: _____

Time	Where is the pain? Rate the pain (01-10) or list word from scale that describes your pain.	What were you doing when the pain started or increased?	Did you take medicine? What did you take? How much?	What other treatments did you use?	After an hour, what is your pain rating?	Other problems or side effects? Comments.
1 Hour						
2 Hour						
3 Hour						
4 Hour						
5 Hour						
6 Hour						
7 Hour						
8 Hour						
9 Hour						