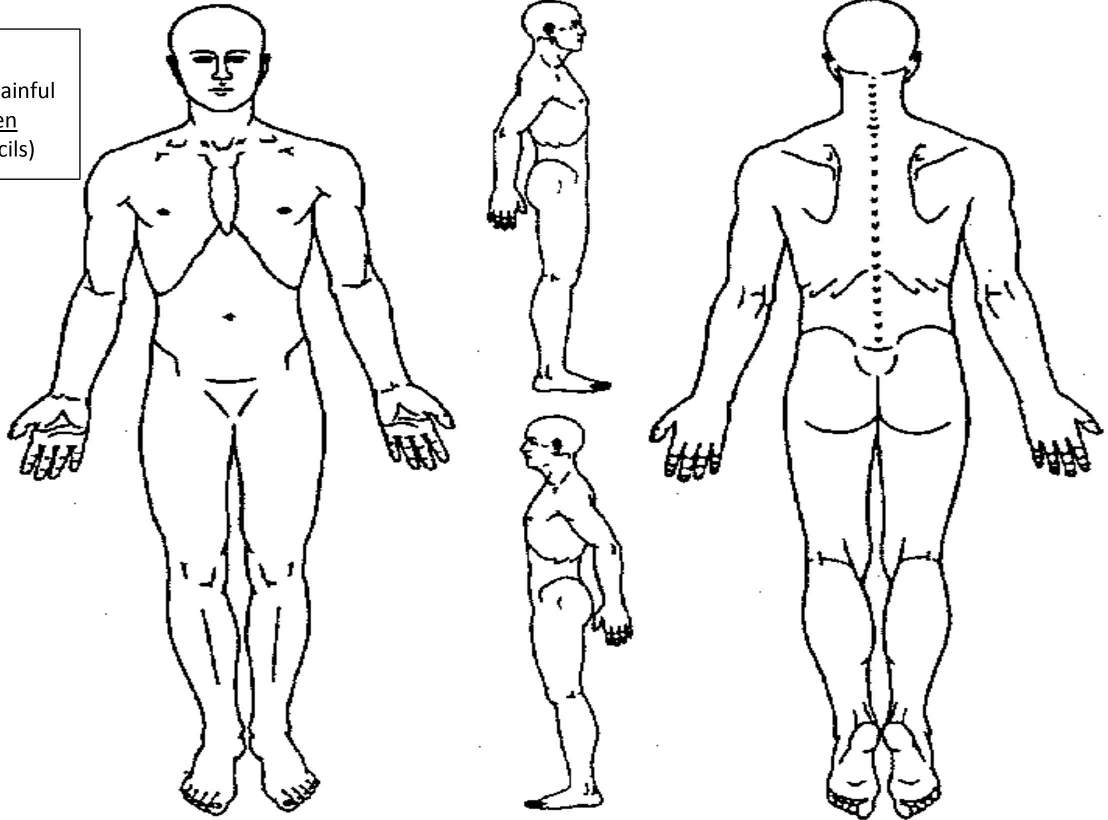
Patient Name: ……………………………………………………………
Dob:
Hospital:
Attach Label

# Diagnostic Block Evaluation Sheet

Procedure: ……………………………………………………………
Doctor: ……………………………………………………………
Date: ……………

**Pain Map:**
Please shade painful areas with a pen (don't use pencils)



## Four Activities Limited by Target Pain:

1: ……………………………………………………………………………
2: ……………………………………………………………………………
3: ……………………………………………………………………………
4: ……………………………………………………………………………

Worst pain ever experienced /10
Worst ever target/index pain /10
Target/Index pain today: /10

## Descriptions:

Target Pain: ……………………………………………………
Other Pains: ……………………………………………………
……………………………………………………………………………
……………………………………………………………………………
……………………………………………………………………………

## Patient Remarks:

Much worse – Worse – Same – Better – Much Better
Activities Restored: 1 - 2 - 3 - 4
Comments:

| 10 | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| 9 | | | | | | | | |
| 8 | | | | | | | | |
| 7 | | | | | | | | |
| 6 | | | | | | | | |
| 5 | | | | | | | | |
| 4 | | | | | | | | |
| 3 | | | | | | | | |
| 2 | | | | | | | | |
| 1 | | | | | | | | |
| 0 | | | | | | | | |
| NRS | Pre | Post | 30min | 60min | 90min | 2h | 3h | 4h |

Please mark 0-10 pain score with a X at the relevant time post block

## Hospital Nurse Remarks:

Signature:

**Instructions:** Please fax, email, post or deliver the completed form to Frankston Pain Management within 3 days of the procedure. A review appointment will be given after the form has been checked by your doctor

## Interpretation and Action Plan:

Signed: Doctor & Date