MATTHEW WELCK
CONSULTANT ORTHOPAEDIC SURGEON
FOOT AND ANKLE SPECIALIST

PAIN DIARY

Patient Name _____

Date of Procedure _____

Injection Site _____

Please indicate the severity of your pain by circling the appropriate number.
Any additional effects of the injection should also be recorded on the back of this sheet.

PRE-INJECTION

0 1 2 3 4 5 6 7 8 9 10
No pain Worst ever pain

IMMEDIATELY POST-INJECTION (i.e. within 15 minutes)

0 1 2 3 4 5 6 7 8 9 10
No pain Worst ever pain

ONE HOUR POST-INJECTION

0 1 2 3 4 5 6 7 8 9 10
No pain Worst ever pain

END OF DAY ONE

0 1 2 3 4 5 6 7 8 9 10
No pain Worst ever pain

END OF DAY TWO

0 1 2 3 4 5 6 7 8 9 10
No pain Worst ever pain

END OF DAY THREE

0 1 2 3 4 5 6 7 8 9 10
No pain Worst ever pain

END OF DAY FOUR

0 1 2 3 4 5 6 7 8 9 10
No pain Worst ever pain

END OF DAY FIVE

0 1 2 3 4 5 6 7 8 9 10
No pain Worst ever pain

END OF DAY SIX

0 1 2 3 4 5 6 7 8 9 10
No pain Worst ever pain

END OF WEEK 1

0 1 2 3 4 5 6 7 8 9 10
No pain Worst ever pain

END OF WEEK 2

0 1 2 3 4 5 6 7 8 9 10
No pain Worst ever pain

Thank you for completing this form.

You must bring this with you when you attend your follow up visit after your injection.