NIPM
NEUROINTERVENTIONAL PAIN MANAGEMENT

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Name:_____ DOB :_____/_____/_____

Diagnostic Block Evaluation

*Please note: This is a test and your **results are temporary**.*

Our medical decision will be based on your responses. Begin recording your responses ***immediately*** after your injection, and return to us as soon as you have it completed.

Injection: Date____/____/____ ☐ Diagnostic ☐ Confirmatory ☐ Rt. ☐ Lt.

Procedure: _____ ☐ 0.5% Bup ☐ 2 % Lido

IMPROVEMENT

List **4 activities** limited by usual pain
Percentage improvement in each activity after injection

Tell us Percentage Improvement
Example:
0%-No Improvement in "Usual Pain"
100%-Complete Improvement

ACTIVITIES	1 hour	2 hours	4 hours	6 hours	12 hours	24 hours

PAIN LEVEL

Please state the number that best describes the pain for which you had the injection:

	TIME	(0-No Pain, 10-Highest Pain)
Immediately Before Procedure		
Immediately After Procedure		
1 hour		
2 hours		
4 hours		
6 hours		
12 hours		
24 hours		

Additional Comments: _____