POST-PROCEDURE EVALUATION

Date:_____ Patient:_____

1. **Rate your back or neck** pain level **CURRENTLY** on a 0-10 scale (0 no pain, 10 worst imaginable)

0 0.5 **1.0** 1.5 **2.0** 2.5 **3.0** 3.5 **4.0** 4.5 **5.0** 5.5 **6.0** 6.5 **7.0** 7.5 **8.0** 8.5 **9.0** 9.5 **10**

2. **Rate your arm/shoulder or leg/buttock** pain level **CURRENTLY** on a 0-10 scale

0 0.5 **1.0** 1.5 **2.0** 2.5 **3.0** 3.5 **4.0** 4.5 **5.0** 5.5 **6.0** 6.5 **7.0** 7.5 **8.0** 8.5 **9.0** 9.5 **10**

3. Please shade in where your pain is located, and place 'x' marks over areas of numbness.