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SPINAL SURGERY
CRANIAL SURGERY
MICRONEUROSURGERY
SPINAL INSTRUMENTATION

Discography and Facet Block Reporting Form

Patient's Name: _____

Date of Test: _____

Time of Injection(s) _____

Type and Level of Injection(s) _____

Doctor Who Performed the Injection(s) _____

How much of your pain was relieved by the injection(s)? _____%

How soon was your pain relieved by the injection(s)? _____

What time did your symptoms begin to return? _____

What time did your symptoms return to their usual level? _____

Please list activities you engaged in during the time between leaving the hospital after the injection and return of symptoms. Place an asterisk (*) beside those activities you might not have been able to do before the injection(s). Use the back of this page for additional comments. Remember to bring this with you to your next office appointment.

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