Injection Questionnaire (Knee & Misc) – Pre-Injection

Name: ____________________________________________

How would you like to be contacted regarding this study: ___ E-Mail/___ Fax /___ Mail

Please give us your Email, or Fax: _______________________________________________

How much pain did you have today on a scale of 0 (No pain) to 10 (Worst pain ever):
Before injection  __________

How many pills of narcotics (vicodin, codeine, norco, etc) do you take per day:
Before injection  __________

Did you have pain that woke you up from sleep or at rest without moving (Circle):
Before injection  ___ YES  /  ___ NO

Night Pain
Rest Pain

___ YES / ___ NO
___ YES / ___ NO

Notes: _______________________________________________________________________________