PAIN ASSESSMENT-PROGRESS NOTE

DATE: / /

Name: _____

DOB:_____

SUBJECTIVE: Please describe your pain :

How did your pain start?

_____

_____

What do you think is causing your pain?

_____

How long have you had the pain? _____

Is it occational ? □ Y □ N

Is it continuous ? □ Y □ N

What makes the pain beter ? _____

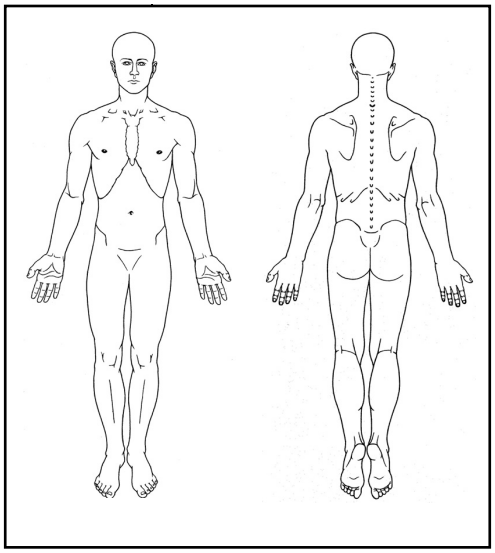
What makes the pain worse ?_____

Is it due to an:

- ❑ accident (MVA)
- ❑ worker's
- ❑ injury

Where is your pain? (See drawing.)

Is it going anywhere else (Draw arrows.)



How does your pain feel ?

❑ aching	❑ cramping	❑ burning	❑ shooting
❑ throbbing	❑ pressure	❑ electric shock	❑ numbing
❑ gnawing	❑ deep aching	❑ hot	❑ itching
❑ _____	❑ squeezing	❑ stabbing	❑ tingling

Do you have any other symptoms in addition to pain ? □ Y □ N

❑ _____	❑ sleep problems	❑ nausea	❑ itching
❑ _____	❑ irritability	❑ vomiting	❑ weakness
❑ fear	❑ loss of appetite	❑ constipation	❑ confusion
❑ anxiety		❑ difficulty gurinatin	❑ sleepiness

Does the pain disturb your

❑ sleep	❑ walking	❑ concentration	❑ relationships
❑ eating	❑ housework	❑ energy	❑ enjoyment of life
❑ self-care	❑ work	❑ mood	❑ recreation?

Are you depressed ? □ Y □ N Does the pain make you feel depressed? □ Y □ N

What have you tried to treat the pain? Do you have any allergies ? □ Y_____ □ N

Medications:	Did it help? How much ?		Side effects?	
❑ _____	❑ Y _____	❑ N	❑ Y _____	❑ N
❑ _____	❑ Y _____	❑ N	❑ Y _____	❑ N
❑ _____	❑ Y _____	❑ N	❑ Y _____	❑ N

Other treatment:	Did it help ? How much ?		Side effects?	
❑ _____	❑ Y _____	❑ N	❑ Y _____	❑ N
❑ _____	❑ Y _____	❑ N	❑ Y _____	❑ N

Do you have any important medical problems?

❑ peptic ulcer disease	❑ edema/swelling of legs	❑ cancer _____
❑ high blood pressure	❑ kidney disease	❑ other _____

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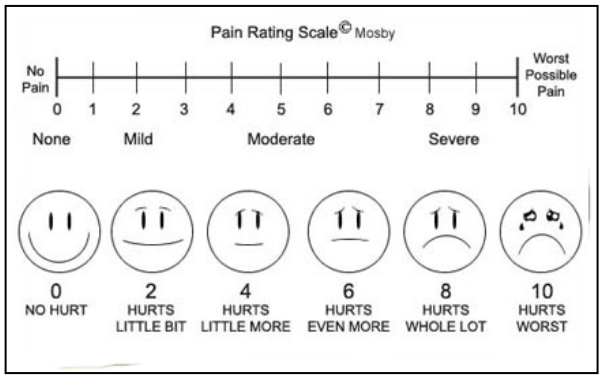
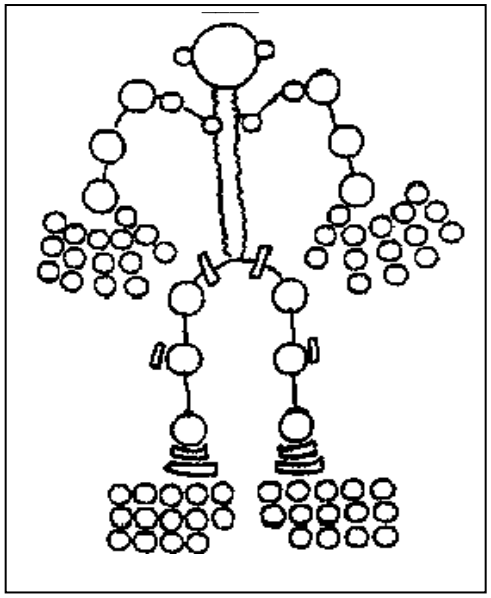
OBJECTIVE:



Pain scale 1-3 mild, 4-7 moderate, 8-10 severe

- ❑ now:
- ❑ on average:
- ❑ best:
- ❑ worst:



VS: BP: _____ HR: _____T: _____RR: _____Weight: ____

Pertinent physical findings:

ASSESSMENT:

PLAN:

Treatment plan :

❑ X-ray _____ ❑ Lab _____ ❑ Consultation _____ ❑ other _____

Goals for Therapy :

❑ relieve pain ❑ get back to work ❑ improve sleep ❑ other _____

Educate Patient □ Brochure Given □

Non-pharmacological Therapy:

❑ ice	❑ physical therapy	❑ cognitive behavioral therapy
❑ heat	❑ herbal remedy	❑ relaxation techniques
❑ exercise	❑ massage	❑ other: _____
❑ support group	❑ acupuncture	

Referral to pain specialist: □ Y _____ □ N □ See intra-professional fax referral form

Counseling if needed: □ Y _____ □ N

Signature: _____