

PAIN ASSESSMENT PROGRESS NOTE

DATE: / /

Name:
DOB
Medical Record Number:

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 **occasional**? Y N

Is it **continuous**? Y N

What makes the pain **better**? _____

What makes the pain **worse**? _____

Is it **due** to an:

- accident (MVA)
- worker's
- injury

How does your pain **feel**?

- | | | | |
|------------------------------------|--------------------------------------|---|-----------------------------------|
| <input type="checkbox"/> aching | <input type="checkbox"/> cramping | <input type="checkbox"/> burning | <input type="checkbox"/> shooting |
| <input type="checkbox"/> throbbing | <input type="checkbox"/> pressure | <input type="checkbox"/> electric shock | <input type="checkbox"/> numbing |
| <input type="checkbox"/> gnawing | <input type="checkbox"/> deep aching | <input type="checkbox"/> hot | <input type="checkbox"/> itching |
| <input type="checkbox"/> _____ | <input type="checkbox"/> squeezing | <input type="checkbox"/> stabbing | <input type="checkbox"/> tingling |

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

- | | | | |
|----------------------------------|---|---|-------------------------------------|
| <input type="checkbox"/> _____ | <input type="checkbox"/> sleep problems | <input type="checkbox"/> nausea | <input type="checkbox"/> itching |
| <input type="checkbox"/> _____ | <input type="checkbox"/> irritability | <input type="checkbox"/> vomiting | <input type="checkbox"/> weakness |
| <input type="checkbox"/> fear | <input type="checkbox"/> loss of appetite | <input type="checkbox"/> constipation | <input type="checkbox"/> confusion |
| <input type="checkbox"/> anxiety | | <input type="checkbox"/> difficulty urinating | <input type="checkbox"/> sleepiness |

Does the pain **disturb** your

- | | | | |
|------------------------------------|------------------------------------|--|--|
| <input type="checkbox"/> sleep | <input type="checkbox"/> walking | <input type="checkbox"/> concentration | <input type="checkbox"/> relationships |
| <input type="checkbox"/> eating | <input type="checkbox"/> housework | <input type="checkbox"/> energy | <input type="checkbox"/> enjoyment of life |
| <input type="checkbox"/> self-care | <input type="checkbox"/> work | <input type="checkbox"/> mood | <input type="checkbox"/> recreation? |

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

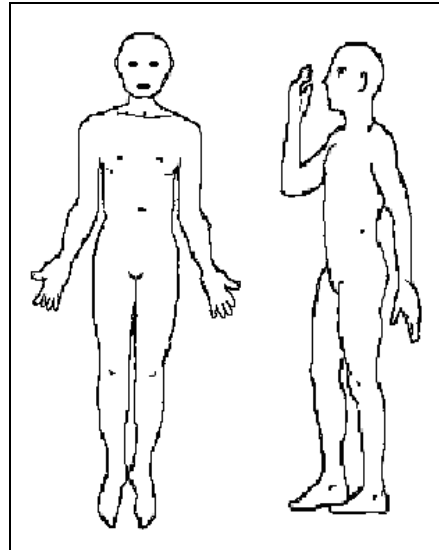
What have you tried to **treat** the pain? Do you have any **allergies**? Y _____ N

Medications:	Did it help? How much?	Side effects?
<input type="checkbox"/> _____	<input type="checkbox"/> Y _____	<input type="checkbox"/> N <input type="checkbox"/> Y _____
<input type="checkbox"/> _____	<input type="checkbox"/> Y _____	<input type="checkbox"/> N <input type="checkbox"/> Y _____
<input type="checkbox"/> _____	<input type="checkbox"/> Y _____	<input type="checkbox"/> N <input type="checkbox"/> Y _____
Other treatment:	Did it help? How much?	Side effects?
<input type="checkbox"/> _____	<input type="checkbox"/> Y _____	<input type="checkbox"/> N <input type="checkbox"/> Y _____
<input type="checkbox"/> _____	<input type="checkbox"/> Y _____	<input type="checkbox"/> N <input type="checkbox"/> Y _____

Do you have any important **medical problems**?

- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> peptic ulcer disease | <input type="checkbox"/> edema/swelling of legs | <input type="checkbox"/> cancer _____ |
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> kidney disease | <input type="checkbox"/> other _____ |

Where is your pain? (See drawing.)
Is it **going anywhere** else? (Draw arrows.)



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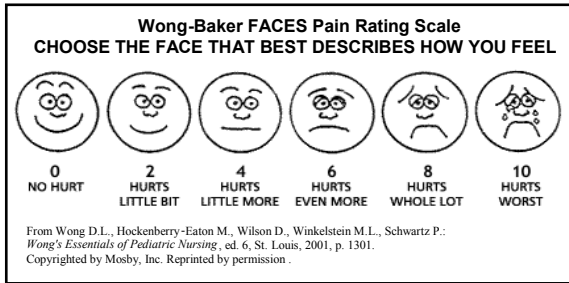
DATE: / /

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OBJECTIVE:



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

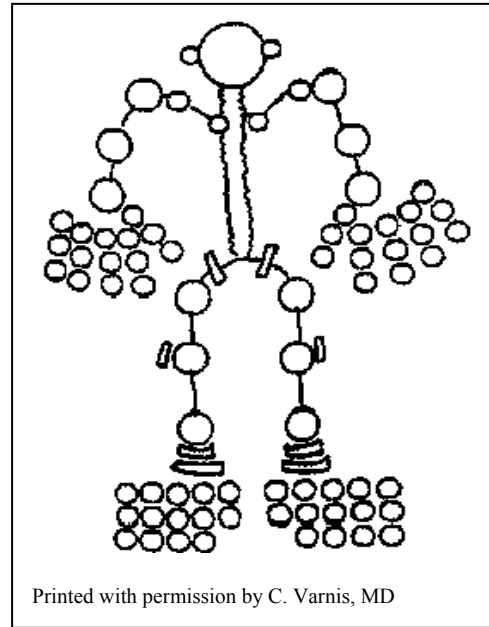
- now: _____
- on average: _____
- best: _____
- worst: _____

VS: BP: _____ HR: _____ T: _____ RR: _____ Weight: _____

Pertinent physical findings:

Ambulation: limping cane walker wheelchair

ASSESSMENT:



PLAN:

Diagnostic 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
- heat
- exercise
- support group
- physical therapy
- chiropractor Rx
- massage
- acupuncture
- cognitive behavioral therapy
- relaxation techniques
- other: _____

Medications:

Mild (1-3)-moderate(4-7):

- APAP: _____
- NSAID/Cox-2: _____
- Combination: _____

Moderate-severe(4-10):

- Long acting opioid: _____
- Breakthrough dose (10% of 24 hr total q1 hr):
- Bowel Regimen – Senna
- Bowel Regimen – Sorbitol

Adjuvant medications: _____

Referral to pain specialist:

Y _____ N

See intra-professional fax referral form

Counseling if needed:

Y _____ N

Follow-up: _____ Signature: _____