

Pain Clinic Patient Progress Note

Date last seen: _____

How would you best describe your pain? (please check all that apply)

Dull, throbbing, aching

Shock-like, numb or tingling

Burning

Other

Please rate your pain by circling the one number that best describes your pain on the average over the past few days (While taking your pain medication)

1 2 3 4 5 6 7 8 9 10

What makes your pain worse?

standing

walking

sitting

bending or twisting

ice

heat

What makes your pain better?

standing

walking

sitting

bending or twisting

ice

heat

To what degree has pain interfered with the following activities 1=no interference, 10=maximum interference

Your sleep 1...2...3...4...5...6...7...8...9...10

General activity 1...2...3...4...5...6...7...8...9...10

Mood 1...2...3...4...5...6...7...8...9...10

Walking ability 1...2...3...4...5...6...7...8...9...10

Normal work (at home and outside) 1...2...3...4...5...6...7...8...9...10

Relations with others 1...2...3...4...5...6...7...8...9...10

Enjoyment of life 1...2...3...4...5...6...7...8...9...10

Did your pain medicine cause a problem?

None Mild Moderate Severe

Nausea				
Constipation				
Drowsiness				
Confusion				
Dry mouth				
Headache				
Weight gain				
Sexual problems				

List all Medications & dosages you currently take

Did you achieve your physical goals since your last visit? (activities that your pain prevented you from doing)

No

Didn't try

almost achieved

achieved

achieved and more

What new goals have you made?

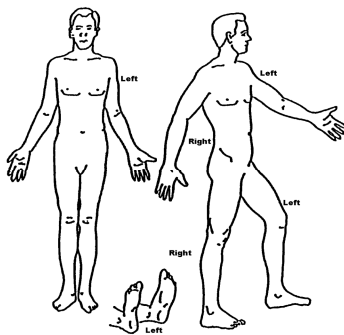
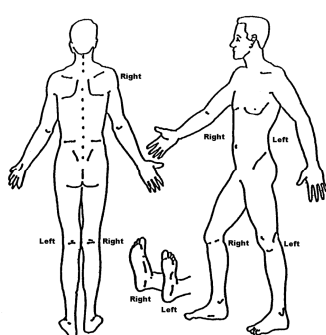
Please indicate where your present pain is:

/// Stabbing

XXX Burning

==== Numbness

000 Pins & Needles



Since your last visit, have you had any changes to:

Your Medical History: _____

Your Surgical History: _____

Have you experienced any major life changes/events: _____

Please list concerns, in order of importance, that you would like to discuss today _____

Place sticker here

Date _____