PROGRESS NOTE: CHRONIC PAIN MANAGEMENT

Patient Name: _____   Date of Visit: _____

DOB: _____   Chart Number: _____

ANALGESIA

Scale of 0-10 (0 = no pain; 10 = worst pain imaginable) rank:

1. What was your pain level on average during the past week? _____

2. What was your pain level at its worst during the past week? _____

3. Compare your average pain during the past week with the average pain you had before you were treated with your current pain relievers. What percentage of your pain has been relieved? _____

4. Is the amount of pain relief you are now obtaining from your current pain relievers enough to make a real difference in your life?
Yes _____   No _____

ADVERSE EVENTS

Is patient able to tolerate current pain relievers?
Yes _____   No _____

Is patient experiencing any side effects from current pain relievers? (i.e. constipation, itching, mental clouding, other)
Yes _____   No _____
Detail:

INTERIM HISTORY

Employment:

Social Support:

Mental Health:

Physical Activity:

Social Activity:

ACTIVITIES OF DAILY LIVING

Physician observation comparing usual functioning during the past month with usual functioning before being treated with current pain reliever(s):

B = Better   S = Same   W = Worse

Physical functioning: _____

Family relationships: _____

Social relationships: _____

Sleep patterns: _____

POTENTIALLY ABERRANT DRUG-RELATED BEHAVIOR

Using EtOH?	Yes	No
Using illicit drugs?	Yes	No
Requests frequent early renewals	Yes	No
Increased dose without authorization	Yes	No
Reports lost or stolen prescriptions	Yes	No
Attempts to obtain prescriptions from other doctors	Yes	No
Changes route of administration	Yes	No

ASSESSMENT/PLAN

□ FAQ performed   □ Screened for depression
□ Care Plan reviewed/updated
□ Urine drug screen performed
          Result:

□ Continue regimen
□ Changes made:
_____
_____
_____
_____

Next visit: _____