Chronic Pain Management Progress Note

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_____

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:_____

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:

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