

Department of Family Medicine and Community Health

Patient Registration Stamp

PAIN PROGRESS NOTE
(Attach patient completed Brief Pain Inventory)

Date: \_\_\_\_\_

Pain diagnosis: \_\_\_\_\_
Current Analgesic Medication Review : (Names and doses) Current Non-pharmacological Therapies:
Opioid analgesic(s): Injections/Surgery
Non-opioid analgesics(s): Physical Therapy
Antidepressant(s): Mental Health
Neuropathic(s): Exercise/stretching
Topical Agent(s): Complementary/Alternative
Other medication(s): Other

Analgesia effectiveness and Functional Status

(review Brief Pain Inventory from prior and current visit)

Worse Same Better

Is patient's pain today [ ] [ ] [ ]

Is patient's functional status [ ] [ ] [ ]

Is the amount of pain relief currently experienced by patient adequate from the patient's view? [ ] Yes [ ] No

Review for Medication Safety and Behavior/Agreement Compliance: Note any specific concerning behavior:

- 1. Keeps all referrals & appointments [ ] No [ ] Yes, comment
2. Unsafe or inappropriate medication usage [ ] No [ ] Yes, comment
3. Refill irregularities [ ] No [ ] Yes, comment
4. Behavior Suggestive of Addiction [ ] No [ ] Yes, comment
5. Sedation, Intoxication, or Mood changes [ ] No [ ] Yes, comment

Healthcare Provider Signature \_\_\_\_\_

Patient Name: \_\_\_\_\_

Medical Record # \_\_\_\_\_

Date of birth: \_\_\_\_\_

**Adverse/Side Effects**  Healthcare Provider reviewed with patient

Ask patient the following:	None	Mild	Moderate	Severe
1. Nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Constipation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Mental cloudiness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Sweating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Drowsiness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Impact of side effects on patient's function:  
 none  mild  moderate  severe

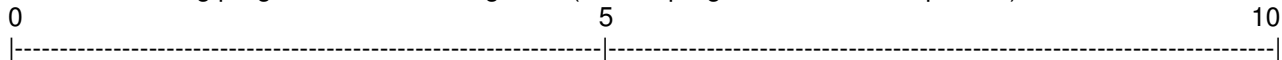
Comments:

**Focused Physical Exam Findings:**

**Review of patient goal setting:**

- Patient goals reviewed:  Exercise  Leisure activities  Return to work  Education
- Other goals:

Patient is making progress on individual goals: (0 = no progress; 10 = accomplished)



**Assessment Summary:**

Does overall benefit of use of opioids for pain relief outweigh side effects and abuse potential?

- Yes  Needs further evaluation  No **If no, specify a transition plan to discontinue opiates below.**

Comments:

**Treatment Plan:**  Continue with present plan

Changes in treatment plan:

<b>Changes in medications:</b>	<b>Changes in non-pharmacological therapies:</b>	<b>Additional testing or monitoring:</b>
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- Referrals made today: Specify \_\_\_\_\_
- Toxicology screen today: Specify \_\_\_\_\_
- Complete medication list reviewed and updated. Comment: \_\_\_\_\_
- Date of last review with patient of pain agreement (annually, and as needed) \_\_\_\_\_

**Healthcare Provider Signature** \_\_\_\_\_

I have personally reviewed the findings and management plan for this patient as described by Dr. \_\_\_\_\_. I agree with the plan as outlined to me. I  did  did not interview and examine the patient.

\_\_\_\_\_  
Attending Signature

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Pager #