UMassMemorial

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:**
Opiioid 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	□	□	□	□
2. Vomiting	□	□	□	□
3. Constipation	□	□	□	□
4. Itching	□	□	□	□
5. Mental cloudiness	□	□	□	□
6. Sweating	□	□	□	□
7. Fatigue	□	□	□	□
8. Drowsiness	□	□	□	□
9. Other:	□	□	□	□

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: (O = no progress; 10 = accomplished)
0 5 10
|----------|----------|

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:

Changes in medications:	**Changes in non-pharmacological therapies:**	**Additional testing or monitoring:**

□ 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 #