



Department of Family Medicine and Community Health

Patient Registration Stamp

**PAIN PROGRESS NOTE**  
**(Attach patient completed Brief Pain Inventory)**

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

Pain diagnosis: _____	
<b>Current Analgesic Medication Review : (Names and doses)</b>	
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 \_\_\_\_\_

**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"/>

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

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

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

### Impact of side effects on patient's function:

none  mild  moderate  severe

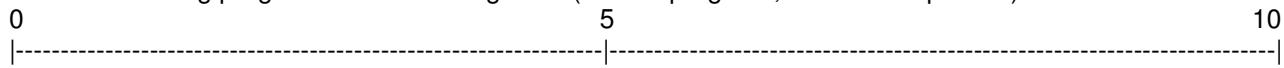
### Comments:

### **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:

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.  did  did not interview and examine the patient.

Attending Signature

Printed Name

Pager #