Pain Management: Return Visit Note

Please describe the state of your pain since your last visit:

1. Rate the average severity of your pain:

WITHOUT MY MEDICATIONS:

0 1 2 3 4 5 6 7 8 9 10

NO PAIN ... WORST IMAGINABLE

WITH MY MEDICATIONS:

0 1 2 3 4 5 6 7 8 9 10

NO PAIN ... WORST IMAGINABLE

3. Mark the words that best describe your pain:

☐ Burning	☐ Aching	☐ Sharp	☐ Constant
☐ Electric	☐ Throbbing	☐ Stabbing	☐ Occasional
☐ Prickling	☐ Dull	☐ Shooting	☐ Frequent
☐ Numbing	☐ Cramping	☐ Stinging	☐ Rare

5. Since you were last seen, have there been any changes in your overall health? If so, explain:

____

____

____

7. Since you were last seen, have there been any changes in your medications or known allergies? If so, list:

____

____

____

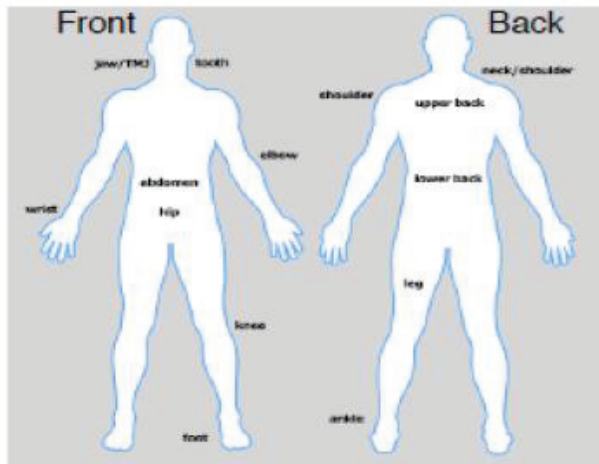
NURSE COMPLETE – Vital signs:

P: ______ R:______ Temp:______ BP:_________ SpO2:______

Ht:_______ Wt:________ BMI:________

Nurse signature:___________________Date/Time:____________

2. Shade your painful areas:



4. What positive changes have you made to improve your pain?
   - ☐ Quit/decreased smoking
   - ☐ Attempted to lose weight/ate healthier
   - ☐ Became more active/flexible
   - ☐ Took part in relaxation/meditation
   - ☐ Volunteered/went back to work

6. What medication related side effects have affected you?
   - ☐ Constipation ☐ Nausea ☐ Dizziness
   - ☐ Drowsiness ☐ Trouble concentrating
   - ☐ Sexual problems ☐ Sleep disturbance

8. Have you considered hurting yourself or others?
   - ☐ Yes ☐ No

PROVIDER NOTES:

Provider signature:____________________ Date/Time:________

____
Patient's Signature Date/Time

____ ____
Signature of Authorized Person Date/Time Relationship to Patient

If limited English proficient or hearing impaired, offer interpreter at no additional cost:

☐ Interpreter Accepted ____ ☐ Interpreter Refused

(Name/Number of Person/Services Chosen/Used)

TMC

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803195 R 6/27/2015

Patient Name:___________________________

DOB:____________________

(or use patient label)

Name / MR # / Label