Chronic Pain Management Progress form
Updated 11/17/11

Patient Name_____ Date_____

Current Pain Medications (include dose and frequency)

How much relief have your pain meds provided this month?

None 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Pain intensity and interference

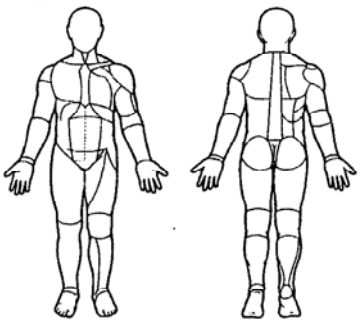
In the last month, on average, how would you rate your pain? Use a scale from 0 to 10, where 0 is "no pain" and 10 is "pain as bad as could be"? [*That is, your usual pain at times you were in pain.*]

No pain										Pain as bad as could be
0	1	2	3	4	5	6	7	8	9	10

In the last month, how much has pain interfered with your daily activities? Use a scale from 0 to 10, where 0 is "no interference" and 10 is "unable to carry on any activities"?

No interference										Unable to carry on any activities
0	1	2	3	4	5	6	7	8	9	10

Diagram your pain:



What where your <u>able to do</u> this month which you couldn't do without medications?

What would you like to do but <u>can't</u> do because of your pain?

What is your overall quality of life? 1 2 3 4 5 6 7 8 9 10
Poor Excellent

What side effects are you experiencing from your medications?

Nausea	Vomiting	Constipation	Lack of appetite	Tiredness
Itching	Nightmares	Sweating	Trouble sleeping	Difficulty thinking

Did you run out of pain meds early? Y N
Did you get pain medications from another person or provider? Y N
Did you use your pain medications for non-pain reasons?
(e.g. Anxiety/stress/trouble sleeping) Y N
Did you drink alcohol? Y N
Did you use marijuana or other street drugs? Y N
How well are you sleeping?
Do you sleep all night and wake up rested? Y N
Do you have trouble falling asleep? Y N
Do you have trouble staying asleep? Y N
Did you provide a urine sample today? Y N

<u>Please fill in PHQ-9 screen on the back of this form</u>

Provider use
MED:

_____
Patient Signature

PHQ-9 --- Scoring Tally Sheet

Patient Name_____ Date_____

1. Over the last 2 weeks, how often have you been bothered by any of the following problems? Read each item carefully, and mark your response.

	Not at all	Several days	More than half the days	Nearly every day
	0	1	2	3
Little interest or pleasure in doing things				
Feeling down, depressed, or hopeless				
Trouble falling asleep, staying asleep, or sleeping too much				
Feeling tired or having little energy				
Poor appetite or overeating				
Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down				
Trouble concentrating on things such as reading the newspaper or watching television				
Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual				
Thinking that you would be better off dead or that you want to hurt yourself in some way				
Totals				

2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not Difficult At All	Somewhat Difficult	Very Difficult	Extremely Difficult
0	1	2	3

CAGE-AID Questionnaire

When thinking about drug use, include illegal drug use and the use of prescription drugs other than prescribed.

Questions	**YES**	**NO**
Have you ever felt that you ought to cut down on your drinking or drug abuse?		
Have people annoyed you by criticizing your drinking or drug abuse?		
Have you ever felt bad or guilty about your drinking or drug abuse?		
Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?		

Scoring

Regard one or more positive responses to the CAGE-AID as a positive screen.

Psychometric Properties		
The CAGE-AID exhibited	**Sensitivity**	**Specificity**
One or more **YES** responses	.79	.77
Two or more **YES** responses	.70	.85