Chronic pain Management form
Updated 01/05/2019

Patient Name:_____ Date:_____

Current Pain Medications:

1. What number best describes your pain on average in the past week:

0 1 2 3 4 5 6 7 8 9 10

No pain — Pain as bad as you can imagine

2. What number best describes how, during the past week, pain has interfered with your enjoyment of life?

0 1 2 3 4 5 6 7 8 9 10

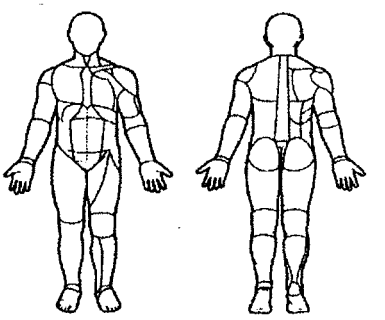
Does not interfere — Completely interferes

3. What number best describes how, during the past week, pain has interfered with your general activity?

0 1 2 3 4 5 6 7 8 9 10

Does not interfere — Completely interferes

Diagram your pain:



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 none pain issues? Y N
(e.g. Anxiety/stress/insomnia)

Did you drink alcohol? Y N

Did you use street drugs? Y N

Did you use Marijuana? Y N

Do you sleep well? Y N

_____
Patient Signature

For Provider use below

MED:

Risk:	Low	Interm	High
UDS:	N/A	approp.	abnormal