Pain Institute

Patient Name_____ Date of Birth_____

LOCATION OF PAIN

_____

My pain is

Throbbing Stabbing Pinching

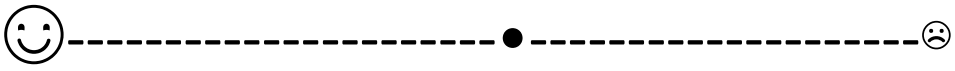
Tender Dull Burning

Aching Shooting Steady

Use the scale below to better estimate the level of pain you are experiencing with and without medication.

with medication

0 1 2 3 4 5 6 7 8 9 10



without medication

0 1 2 3 4 5 6 7 8 9 10

1-1 Very little or hardly noticeable pain.

2-3 Pain is present, but you may have to stop and think about it to really tell if it is there or gone. You seem just fairly comfortable.

4-5 You now notice your pain, perhaps at rest or during activity. It may interfere with your activities. Level 4 is the level at which it is a good idea to start introducing some avenues of relief.

6-7 Your pain is distracting you, but you may be able to focus on something else rather than the pain for a short period of time. You may be grinding your teeth to carry out activities.

8-9 Your pain may be severe enough that it makes you stop in the middle of an activity, or not be able to complete it at all. It is difficult to think of anything else but your pain at this level. You may be uncomfortable even at rest of quiet times.

10 Your pain is now the worst you can imagine. It is important to remember that the best way to treat the pain is to stay ahead of its increasing intensity and to maintain a regular schedule of pain relief. **Do not wait for level 10 before you discuss options with your healthcare provider.**

Patient Signature_____Date_____

OFFICE USE ONLY

NAME_____INSURANCE_____Date_____

HT: _____ WT: _____ BP: _____ P:_____

	ORDER	DATE/TIME		ORDER	DATE/TIME
CMBB:	_____	_____	**PAIN CREAM:**	_____	_____
TMBB:	_____	_____	**WRIST BRACE:**	_____	_____
LMBB:	_____	_____	**BACK BRACE:**	_____	_____
SI JOINT:	_____	_____	**KNEE BRACE:**	_____	_____
TPI:	_____	_____	**CBD OIL:**	_____	_____
Joint:	_____	_____	**Narcan/Evzio:**	_____	_____

Records:_____

Radiology:_____

Current Treatment: _____

Pregnancy Test: Pos Neg

Temperature: _____

DO UDS: YES NO

Medication: _____

Strength: _____

Date Filled: _____

Qty Filled: _____

Qty Remaining: _____

Verified/ Bottle: _____

FOLLOW UP IN _____ DAYS

APPT DATE _____ TIME _____

NEED MD VISIT YES NO

Provider Signature: _____

Medication: _____

Strength: _____

Date Filled: _____

Qty Filled: _____

Qty Remaining: _____

Verified/Bottle: _____