Questions: DATE:

Name: **DOB:** **MRN:**

What is the HIGHEST your pain has been? In the past 2 weeks

1 2 3 4 5 6 7 8 9 10

What is the LOWEST you can get it to go? In the past 2 weeks

1 2 3 4 5 6 7 8 9 10

What is your pain score right now?

1 2 3 4 5 6 7 8 9 10

How many hours does your pain medication last?

1 2 3 4 5 6 7 8 9 10 11 12 HOURS

Any constipation on the medication? Yes/No

Name 3 things your pain medicine helps you to be able to DO!!

1. _____2._____3._____

Name TOP 3 places that hurt the most and when did it start:

1. _____

2. _____

3. _____

Name 3 things you do to get your pain to go down:

1. _____

2. _____

3. _____

What can we do for you medically today?

Check all that apply:
- ◯ Medication refills only (NO CHANGE)
- ◯ Procedures/Injections
- ◯ Physical therapy
- ◯ Something else: _____