Ford Center for Pain Management

PATIENT NAME_____ **DATE**_____

Home phone_____ **Cell phone**_____ **Ok to leave messages? (Circle) YES / NO**

Your pharmacy name and location: _____

Where do you hurt the most today?

_____

List any allergies you may have:

_____

List any blood thinners that you have taken in the last seven days:

_____

Please list how frequently your bowels move while you take your pain medications (circle one):

every (A.) 1-2 days, (B.) 3-5 days, (C.) 6 or more days

Activities of Daily Living

Please indicate whether your functioning with the current pain therapy and medications is Better, the same, or Worse since your last assessment.

	Better	Same	Worse
1. Physical functioning	☐	☐	☐
2. Family relationships	☐	☐	☐
3. Social relationships	☐	☐	☐
4. Mood	☐	☐	☐
5. Sleep patterns	☐	☐	☐
6. Overall functioning	☐	☐	☐

Does your **pain medication** cause you to itch, feel sick or get sleepy?

☐ Yes ☐ No

Have you experienced any new side effects from your pain medicine since your last visit?

☐ Yes ☐ No

Pain Level

On a scale of 0 to 10, answer the following questions:

0 = "no pain"

10 = "the most severe pain I've ever experienced"

1. What was your lowest pain score last month? (Please circle one.)

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Worst Pain**

2. What was your highest pain score last month?

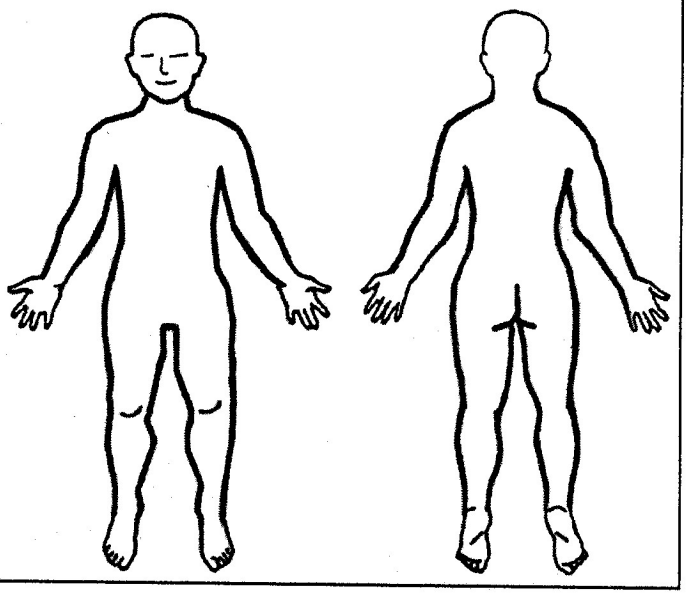
No Pain 0 1 2 3 4 5 6 7 8 9 10 **Worst Pain**

3. What is your pain level today?

No Pain 0 1 2 3 4 5 6 7 8 9 10 **Worst Pain**

Please mark the location of your pain

FRONT **BACK**



OVER PLEASE ...

PROVIDER USE ONLY, FILL DATE: _____

NEXT APPOINTMENT DATE: _____

Ford Center for Pain Management

PATIENT NAME_____ **DATE**_____

Please circle any of the following that you experience:

itching – chills – fever – mental cloudiness – fatigue – drowsiness

glasses – contacts – blurred vision – eye drainage – eye pain – hearing

difficulties –ringing in ears – sinus congestion – frequent nose bleeds

chest pain – swelling ankles or feet – irregular heart rate – shortness of breath

difficulty breathing – cough (chronic) – exposure to TB – wheezing – diarrhea

nausea – vomiting – constipation – abdominal pain – heartburn – bloating

loss of appetite – acid reflux – difficulty swallowing – hemorrhoids – urinary

incontinence – blood in urine – frequent UTIs – history of abuse – low back pain

joint stiffness – joint pain – arm pain – muscle pain – leg pain – neck pain

dizziness – fainting – headaches – numbness – weakness – tingling – seizures

memory loss – easy bruising – excessive bleeding – heat intolerance – hair loss

cold intolerance – excessive sweating – hot flashes – depression – anxiety

Please list any medicines that have been added or changed since last month:

_____

_____

_____

_____

_____

_____

_____

Overall is your pain (circle one) the same, decreased, or increased since last month?