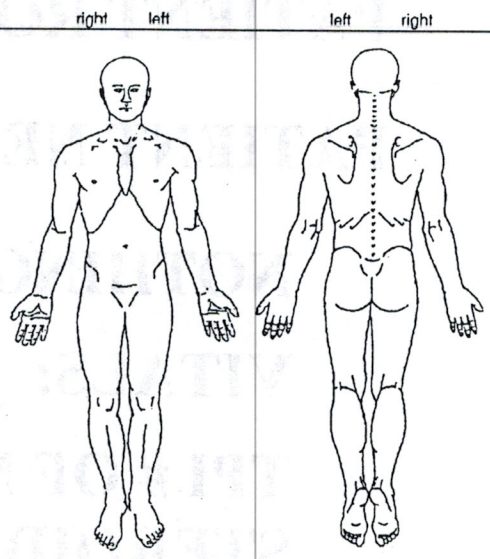
Rex Pain Management Center

patient identification

List in order of importance the areas of pain (include left/right)



_____

_____

_____

_____

Circle your pain score

0 1 2 3 4 5 6 7 8 9 10

no pain mild discomfort distress horrible excruciating

Describe your pain: (circle ALL that apply)

Throbbing Shooting Sharp Cramping Hot/Burning Aching Stabbing Other: _____

Things that make your pain <u>BETTER</u>: (circle ALL that apply)

Heat Cold Lying down Sitting Standing Walking Climate Fatigue Coughing Massage Alcohol Medication Other:_____

Things that make your pain <u>WORSE</u>: (circle ALL that apply)

Heat Cold Lying down Sitting Standing Walking Climate Fatigue Coughing Massage Alcohol Medication Other:_____

Activities affected by your pain are: (circle ALL that apply)

Falling Asleep Staying Asleep Social Interactions Sexual Activity Household Chores Work/School Leisure Activities

My pain treatments help me function better in the following aspects of my life: (circle ALL that apply)

General Activity Mood Walking Ability Work (Job/Home) Relationships with Others Sleep Enjoyment in Life

Other :_____

I have experienced the following EVERY DAY for the past 2 weeks (circle ALL that apply, or "None of the Above")

Depressed mood Insomnia Decreased interest Guilt Decreased Energy Concentration Problems

Change in Appetite Suicidal thoughts Agitation None of the Above

Changes in medical history/recent surgeries since last visit _____

Names of medication refills needed to be written today:

_____ _____ _____ _____ _____

Medication allergies:_____

Anticoagulants/blood thinners currently taking:_____

Pharmacy name/phone number:_____

_____R.N. _____Date/Time

Notes: