PAIN ( ) Yes ( ) No

Pain location 1 [Search] [ ]

Notes [ ]

Type
( ) Acute ( ) Recent onset ( ) Chronic

Intensity scale
( ) 0 ( ) 1 ( ) 2 ( ) 3 ( ) 4 ( ) 5 ( ) 6 ( ) 7 ( ) 8 ( ) 9 ( ) 10

Precipitating factors [ ]

Control measures (Mark all that apply)

- [ ] 1 - Rest
- [ ] 2 - Massage
- [ ] 3 - Heat/Cold
- [ ] 4 - Medication
- [ ] 5 - TENS unit
- [ ] 6 - Relaxation
- [ ] 7 - Music therapy
- [ ] 8 - Biofeedback
- [ ] 9 - Other (specify) [ ]

Best response to control measures
( ) 0 ( ) 1 ( ) 2 ( ) 3 ( ) 4 ( ) 5 ( ) 6 ( ) 7 ( ) 8 ( ) 9 ( ) 10

Does the pain radiate? ( ) Yes ( ) No

Please describe the pain (use patient's own words). [ ]

What is pain preventing patient from doing? [ ]

How long does the pain last? [ ]

Are there times of day/night when pain is worse? [ ]

Is there a pattern to the pain? ( ) Yes ( ) No

Does the pain vary? ( ) Yes ( ) No

Physician ( ) Aware or ( ) Notified

Notes [ ]