OLYMPIC
INTERNAL MEDICINE, INC. P.S.

# Pain Patient Progress Note

Patient Name:______________________________ DOB:____________

Date last seen:________________

**How would you best describe your pain? (please circle all that apply)**
Dull, throbbing, aching Shock-like, numb or tingling Burning Other

**Please rate your pain by circling the one number that best describes your pain on the average over the past few days (While taking your pain medication) 1=low pain 10=high pain**
1 2 3 4 5 6 7 8 9 10

**What makes your pain worse?**
standing walking sitting bending or twisting ice heat

**What makes your pain better?**
standing walking sitting bending or twisting ice heat

**To what degree has pain interfered with the following activities (please circle)**
1=no interference, 10=maximum interference

| | |
|---|---|
| Your sleep | 1….2….3….4….5….6….7….8….9….10 |
| General activity | 1….2….3….4….5….6….7….8….9….10 |
| Mood | 1….2….3….4….5….6….7….8….9….10 |
| Walking ability | 1….2….3….4….5….6….7….8….9….10 |
| Normal work (at home and outside) | 1….2….3….4….5….6….7….8….9….10 |
| Relations with others | 1….2….3….4….5….6….7….8….9….10 |
| Enjoyment of life | 1….2….3….4….5….6….7….8….9….10 |

**Did your pain medicine cause a problem?**

| | None | Mild | Moderate | Severe |
|---|---|---|---|---|
| Nausea | | | | |
| Constipation | | | | |
| Drowsiness | | | | |
| Confusion | | | | |
| Dry mouth | | | | |
| Headache | | | | |
| Weight gain | | | | |
| Sexual problems | | | | |

Since your last visit, have you had any changes to:

Your Medical History:________________________________________________________________

______________________________________________________________________

Your Surgical History:________________________________________________________________

Have you experienced any major life changes/events:______________________________________

______________________________________________________________________

List all Medications & Dosages you currently take:

| Medication | Strength | How are you taking this medication |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Did you achieve your physical goals since your last visit? (activities that your pain prevented you from doing)

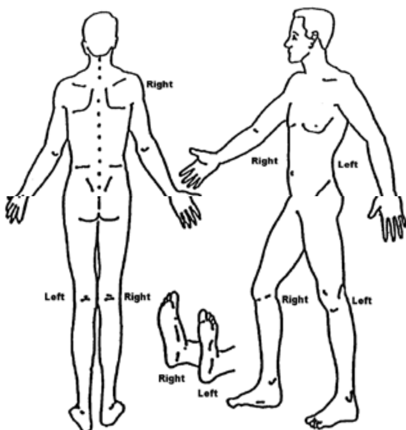
No Didn't try almost achieved achieved achieved and more

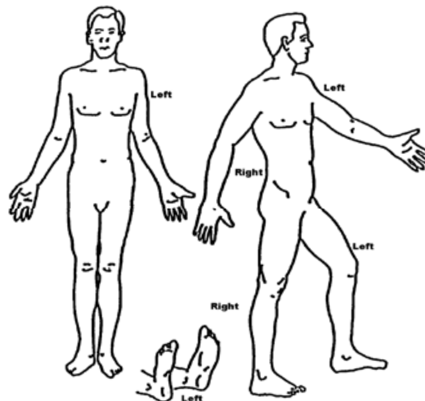
What new goals have you made?

______________________________________________________________________

Please indicate where your present pain is: (Mark on the diagram with the appropriate symbols)

///Stabbing Pain **XXX**Burning Pain ===Numbness **000**Pins & Needles



**Patient Signature:________________________________________ Date:________________**