# Chronic Pain Progress Note

**What medications (prescribed and over the counter) are you taking for your pain (How much and how often?)**

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**How would you best describe your pain? (please check all that apply)**

☐ Dull,throbbing,aching ☐ Shock-like, numb or tingling ☐ Burning

**Has the sort of pain changed since your last visit?** ☐ **No** ☐ **Yes**

**Please rate your pain by circling the one number that best describes your pain on the average over the past few days (Whilst taking your pain medication)**

1 2 3 4 5 6 7 8 9 10

**Please circle the number that best describes your pain at its worst in the last 24 hours**

1 2 3 4 5 6 7 8 9 10

**How many times did your pain get to its worst level during the last 24 hours?**

1-2 3-4 5-6 7-8 more than 8

**What makes your pain worse?**

☐ Standing ☐ walking ☐ sitting ☐bending or twisting ☐ ice ☐ heat

Other______________________________________________________________

**What makes your pain better?**

☐ Standing ☐ walking ☐ sitting ☐bending or twisting ☐ ice ☐ heat

Other______________________________________________________________

**To what degree has pain interfered with the following activities** (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 the pain medicine cause a problem?** | No | Mild | Moderate | Severe |
|---|---|---|---|---|
| *Nausea* | | | | |
| *Constipation* | | | | |
| *Drowsiness* | | | | |
| *Confusion* | | | | |
| *Dry mouth* | | | | |
| *Headache* | | | | |
| *Weight gain* | | | | |
| *Sexual problems* | | | | |

**Did you achieve your physical goals since your last visit? (These are activities that pain had stopped you doing?)**

*☐No ☐Didn't try ☐almost achieved ☐achieved ☐achieved and more*

______________________________________________________________________

**Do you need refills of your pain medications** ☐**yes** ☐**no**

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Please list problems in order of importance you want to discuss with the doctor

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