

# Pain Institute

Patient Name \_\_\_\_\_

Date of Birth \_\_\_\_\_

LOCATION OF PAIN

\_\_\_\_\_

My pain is

Throbbing

Stabbing Pinching

Tender

Dull

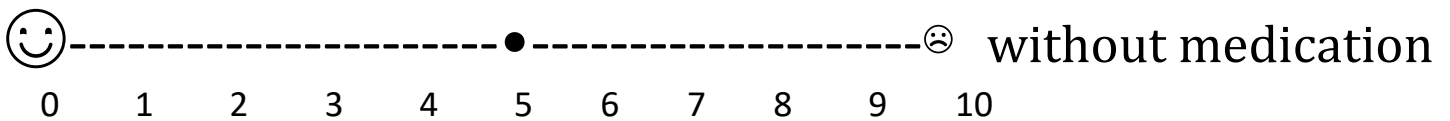
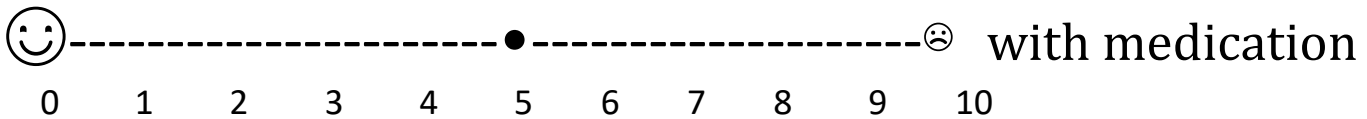
Burning

Aching

Shooting

Steady

Use the scale below to better estimate the level of pain you are experiencing with and without medication.



- 1-1 Very little or hardly noticeable pain.
- 2-3 Pain is present, but you may have to stop and think about it to really tell if it is there or gone. You seem just fairly comfortable.
- 4-5 You now notice your pain, perhaps at rest or during activity. It may interfere with your activities. Level 4 is the level at which it is a good idea to start introducing some avenues of relief.
- 6-7 Your pain is distracting you, but you may be able to focus on something else rather than the pain for a short period of time. You may be grinding your teeth to carry out activities.
- 8-9 Your pain may be severe enough that it makes you stop in the middle of an activity, or not be able to complete it at all. It is difficult to think of anything else but your pain at this level. You may be uncomfortable even at rest or quiet times.
- 10 Your pain is now the worst you can imagine. It is important to remember that the best way to treat the pain is to stay ahead of its increasing intensity and to maintain a regular schedule of pain relief. **Do not wait for level 10 before you discuss options with your healthcare provider.**

Patient Signature \_\_\_\_\_

Date \_\_\_\_\_

**OFFICE USE ONLY**

NAME \_\_\_\_\_ INSURANCE \_\_\_\_\_ Date \_\_\_\_\_

HT: \_\_\_\_\_ WT: \_\_\_\_\_ BP: \_\_\_\_\_ P: \_\_\_\_\_

	ORDER	DATE/TIME		ORDER	DATE/TIME
CMBB:	_____	_____	PAIN CREAM:	_____	_____
TMBB:	_____	_____	WRIST BRACE:	_____	_____
LMBB:	_____	_____	BACK BRACE:	_____	_____
SI JOINT:	_____	_____	KNEE BRACE:	_____	_____
TPI:	_____	_____	CBD OIL:	_____	_____
Joint:	_____	_____	Narcan/Evzio:	_____	_____

Records: \_\_\_\_\_

Radiology: \_\_\_\_\_

Current Treatment: \_\_\_\_\_

Pregnancy Test:    Pos       Neg

Temperature: \_\_\_\_\_

DO UDS:    YES            NO

Medication: \_\_\_\_\_

Strength: \_\_\_\_\_

Date Filled: \_\_\_\_\_

Qty Filled: \_\_\_\_\_

Qty Remaining: \_\_\_\_\_

Verified/ Bottle: \_\_\_\_\_

FOLLOW UP IN \_\_\_\_\_ DAYS

APPT DATE \_\_\_\_\_ TIME \_\_\_\_\_

NEED MD VISIT    YES    NO

Medication: \_\_\_\_\_

Strength: \_\_\_\_\_

Date Filled: \_\_\_\_\_

Qty Filled: \_\_\_\_\_

Qty Remaining: \_\_\_\_\_

Provider Signature: \_\_\_\_\_

Verified/Bottle: \_\_\_\_\_