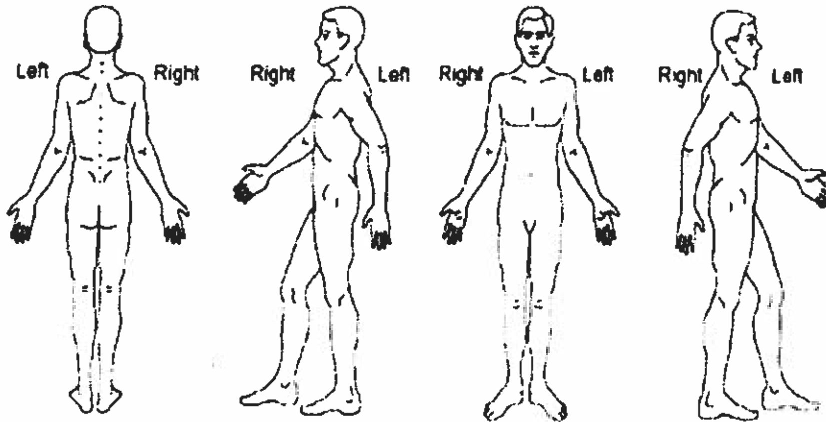
Follow-up Pain Management Visit

Patient's Name: ______________________________ Date: _______________



Use this diagram to mark the location(s) of your pain.

Where is your pain located? ____

If you had a procedure at your last visit, how much pain relief did you obtain? (Please Circle)

None 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

How long did the relief last? __________________________

What percentage improvement do you have today? (Please Circle)

None 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Did you tolerate the procedure well? [ ] Yes [ ] No Please explain:

List the medications we are prescribing to you:

____

What has helped most with your pain? ____________________________________

Are you satisfied with your current level of pain control? [ ] Yes [ ] No

How severe is your pain? (0 is no pain, 10 is worst pain): _____**/10**