VALLEY PAIN CONSULTANTS
An Envision Physician Services Provider

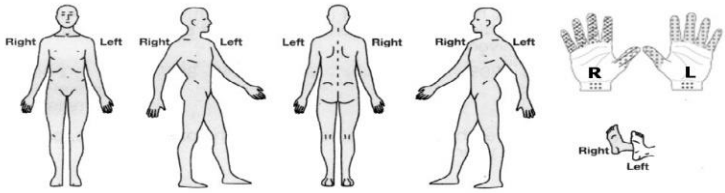
Patient_____

Weight_____Height_____ BP:_____/_____ P:_____ O2_____Pain_____/10

Chief Complaint/Reason for visit:

_____

Where is your most painful area?



AVERAGE DAILY PAIN **(with medications**, if applicable):
(least) (worst)

☐0-☐1-☐2-☐3-☐4-☐5-☐6-☐7-☐8-☐9-☐10

Since your last visit is your pain

☐Better ☐Same ☐Worse

What is the frequency of your pain with current treatment?

☐ Occasional ☐ Frequent ☐ Constant

How would you describe your pain?

☐Sharp ☐Dull ☐ Aching ☐Throbbing ☐Burning

☐Tingling ☐Shooting ☐Cramping

Other_____

What makes your pain worse?

☐ Sitting ☐ Standing ☐ Coughing ☐Twisting

☐Walking ☐Exercise ☐Other_____

What makes your pain better?

☐ Medication ☐ Rest ☐ Sitting ☐Exercise

☐ Other_____

When was the last time you took your pain medication?

☐ Today ☐ Yesterday ☐Other_____

How much pain relief/functional improvement does your current medication provide? (%)

☐NA

☐<10☐10-30☐30-50☐50-70 ☐70-90 ☐90+

Do you feel that you can use less medication than currently prescribed? ☐Yes ☐No

Have you had any procedures to treat your pain in the last two months? ☐Yes ☐No

If yes how much pain relief did you have?
☐None ☐Mild ☐Moderate ☐Significant

Did you have any complications from the procedure? ☐Yes ☐No
If yes please explain_____

What are your treatment goals?

_____

Are you having any side effects from your medication? ☐Yes ☐No
If yes please explain_____
_____

Review of Systems:

Please mark any symptoms you are having

Constitutional: ☐None ☐Fevers ☐Night sweats ☐Chills

Cardiac: ☐None ☐Chest pain ☐Palpitations ☐Shortness of Breath

GI: ☐None ☐Constipation ☐Nausea ☐Vomiting ☐Acid reflux

Neurological: ☐None ☐Sedation ☐Numbness ☐ Weakness ☐NEW bowel or bladder incontinence ☐Suicidal thoughts/planning

COMMENTS:_____
_____
_____
_____