Chronic Pain Follow-Up

Reason for visit:	Current pain medications:
☐ Scheduled follow-up ☐ New complaint	Aberrant drug-taking behavior: how often are you taking your medications? ☐ All the time ☐ More than 50% of the time ☐ Less than 50% of the time ☐ Not taking Adverse effects from medications? ☐ None ☐ Sleepiness ☐ Nausea ☐ Confusion ☐ Vomiting ☐ Other: ☐ Constipation ☐ Fatigue

Analgesia (for the following questions, use the *Pain Rating Scale*: 0 = No Pain 10 = Worst Pain)

a. Please use the pain scale to describe your pain at its **worst in the last week:**	0	1	2	3	4	5	6	7	8	9	10
	No Pain					*Some Pain*					*Worst Pain*
b. Please use the pain scale to describe your pain at its **best in the last week:**	0	1	2	3	4	5	6	7	8	9	10
	No Pain					*Some Pain*					*Worst Pain*
c. Please use the pain scale to describe your pain **on average:**	0	1	2	3	4	5	6	7	8	9	10
	No Pain					*Some Pain*					*Worst Pain*
d. Please use the pain scale to describe your pain **right now:**	0	1	2	3	4	5	6	7	8	9	10
	No Pain					*Some Pain*					*Worst Pain*

Activities of Daily Living (since the last clinic visit how have the following changed?)

Your mood/relations with other people?	Worsened	Same	Some Improvement	Significant Improvement
Your ability to exercise, attend work/school?	Worsened	Same	Some Improvement	Significant Improvement
Your ability to sleep?	Worsened	Same	Some Improvement	Significant Improvement
Your overall degree of discomfort?	Worsened	Same	Some Improvement	Significant Improvement

Physical Examination

BP:	HR:	RESP:	WEIGHT:	HEENT:	HEART:	LUNGS:

Focused examination pain site:	Labs ☐ UDT ☐ Results
Impression (including pain location and etiology, and pain control):	
Plan/discussion (including medications dispensed, refills, diagnostic studies, treatment modalities, labs ordered, UDT ordered and follow up):	

Provider (print name):
Provider (signature):
Date:

CDCR Stamp:
Patient Name:
CDCR #
DOB:

CDCR 7472 (12/09)

ATTACHMENT H