SIDEBAR 2

Initial Pain Assessment Form

Pain Protocol Ordered ☐Yes ☐No

Date of Consult: _____ **Requesting Party:**_____
Clinician:_____ **Reason for Consult:**_____

Patient Name:
MRN:
Age:
Room #:

Diagnosis/CC:_____
HPI:_____
_____
_____
_____
_____
PMH/PSH:_____
Previous Pain Experiences:_____
Allergies/Intolerances:_____

Primary Care MD:_____
Pain MD:_____

Laboratory Data:

Ht:		Wt:	
SCr:		CrCl:	
ALT:		AST:	
Hgb:		Hct:	

Imaging Reports:

Date	Study	Findings

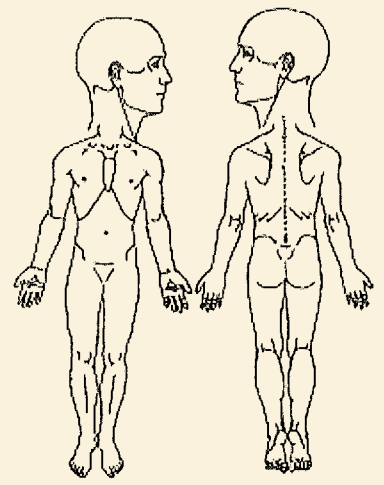
Vitals:

Temp	BP	HR	RR	O2

Prior to Admission : Drug & Dose	**Duration**	**Effective**
Current : Drug & Dose	**24 Hour Use**	

Current Bowel Regimen:_____

Social History /Opioid Risk Assessment		**Elaborate:**
Family History of Substance Abuse	☐ Alcohol ☐ Illegal Drugs ☐ Prescription Drugs	
Personal History of Substance Abuse	☐ Alcohol ☐ Illegal Drugs ☐ Prescription Drugs	
History of Preadolescence Sexual Abuse	☐ Yes ☐ No	
Psychological Disease	☐ Depression ☐ ADHD ☐ OCD ☐ Bipolar ☐ Schizophrenia	
Smoking	☐ Yes ☐ No	PPD:_____



Mark or comment on the above figure where you have pain or problems

Pain Assessment:
Pain Scores (1-10): Current_____ Over last 24 hours: Best_____ Worst_____ Goal_____
Onset/Temporal: _____
Location:_____
Description:_____
Aggravating/Relieving Factors:_____
Previous treatments and Response:_____
Effect: How does pain affect physical and social functioning? _____

Functional pain goals:	☐ Sleep comfortable	☐ Comfort @ rest	**Adverse events (Past or Present):**	☐ Nausea	☐ Vomiting
☐ Total pain relief	☐ Stay alert		☐ Constipation	☐ Itching	☐ Confusion	☐ Sedation

Recommendations:
Non-Pharmacologic: ☐ Massage ☐ Distraction ☐ Relaxation ☐ Exercise ☐ Cold/Heat Application

Pharmacologic :