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Jefferey D. Adair, MD
Fellowship-trained in Pain Management
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FOLLOW UP PAIN ASSESSMENT

DATE: _____ Contact Telephone Number: _____

- What would you like to focus on at today's visit? _____

  _____

- List all known drug allergies _____

- Please check the words that best **describe your pain**. ❑ Constant ❑ Intermittent

  ❑ Aching ❑ Dull ❑ Sharp ❑ Numbing ❑ Burning

  ❑ Sharp ❑ Stabbing ❑ Tingling ❑ Radiating ❑ Cramping

- What makes your pain **worse**? ❑ Standing ❑ Walking ❑ Sitting ❑ Stress ❑ Other (Explain):

  _____

- What makes your pain **better**? ❑ Heat ❑ Ice ❑ Medication ❑ Rest ❑ Other (Explain):

  _____

- Do your pain medications provide **pain relief**? ❑ Yes ❑ No ❑ I do not take pain medications

  If yes, how much **pain relief** do you receive?

  ❑ 10% ❑ 20% ❑ 30% ❑ 40% ❑ 50% ❑ 60% ❑ 70% ❑ 80% ❑ 90% ❑ 100%

- Did you have a **procedure** at your last visit? ❑ Yes ❑ No

  If yes, how much pain relief did you receive?

  ❑ 10% ❑ 20% ❑ 30% ❑ 40% ❑ 50% ❑ 60% ❑ 70% ❑ 80% ❑ 90% ❑ 100%

  How long did the relief last? _____

  How much relief do you still experience? _____

- Since your LAST appointment, have there been any changes in your medical condition, any new symptoms or diagnoses, or any changes in your family or living conditions? ❑ Yes ❑ No

  If yes, please explain _____

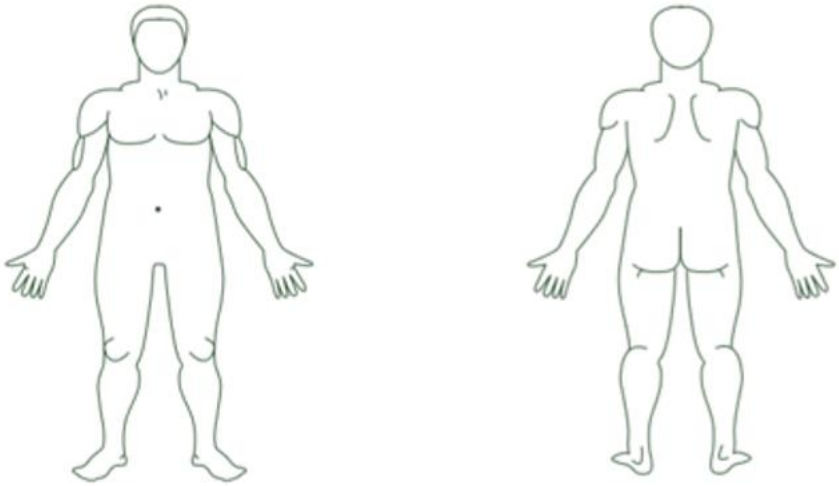
- Since your LAST visit, have you been to any other physician appointments, ER visits, procedures performed, or any new medications prescribed? ❑ Yes ❑ No

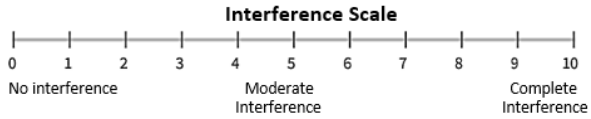
  If yes, please explain _____

PATIENT NAME: _____
Last First Middle Initial Date of Birth

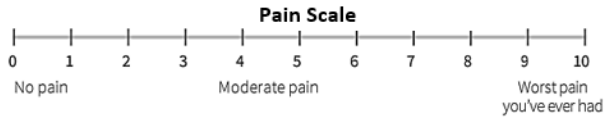
BRIEF PAIN HISTORY

Mark your areas of pain on the diagram below and mark an (X) on the area(s) where your pain hurts the MOST.





- Please mark the number that best describes your **pain** at its **WORSE** in the last week.
  ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10
- Please mark the number that best describes your **pain** at its **LEAST** in the last week.
  ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10
- Please mark the number that best describes your **pain** on **AVERAGE**.
  ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10
- **Please** mark the number that best describes your **pain RIGHT NOW**.
  ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10



Please mark the number that best describes how your pain **<u>interferes</u>** with the following:

- General Activity: ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10
- Mood: ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10
- Walking: ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10
- Standing: ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10
- Sleep: ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10
- Work: ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10
- Relationships: ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10
- Enjoyment of Life: ❑ 0 ❑ 1 ❑ 2 ❑ 3 ❑ 4 ❑ 5 ❑ 6 ❑ 7 ❑ 8 ❑ 9 ❑ 10

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OPIOID TREATMENT AGREEMENT

- I understand that I have signed an opioid treatment agreement and I agree to the conditions contained therein.
- I agree to take my medication **ONLY** as directed.
- I understand that my medication **WILL NOT** be refilled early or prior to my next scheduled appointment.
- I understand that my medication may cause side effects, and that I must notify my physician if any of the following occurs: *sedation, incoordination or loss of motor skills.*
- I understand that it is not advisable to drive or operate heavy machinery while taking pain medication.
- I understand that I must keep my medication in a safe location and that any lost or stolen prescriptions will **NOT** be replaced.
- I understand that some medications may be habit forming or addictive. If I develop intense cravings, medication induced "*highs*," or other psychological effects, I will immediately notify my physician and seek medical attention.
- I agree that I will not use alcohol, illegal substances, or any other substances/medications that are not prescribed to me.
- I agree that I will not sell or give my medications to another individual for any reason.
- I understand that if another physician prescribes me any controlled substances, I **MUST** notify my pain management physician **IMMEDIATELY**.
- I understand that I will not be seen or treated by any other pain management physicians, including but not limited to: Pain Care Consultants (Drs. Nelson, Letchuman, Major), Dr. Brewer, Louisiana Pain Physicians (Drs. Whyte, Tanga), or WK River Cities Interventional Pain (Drs. Noles, Munjampalli, Hursch).
- I agree that my prescribing physician has permission to discuss all diagnostic and treatment details with dispensing pharmacists and other healthcare professionals for the purpose of maintaining accountability.
- I agree to and will comply with random drug screens and pill counts at my physician's discretion.
- I understand that failure to comply with these terms may result in lost privileges for prescription pain medications and/or dismissal from the practice.

_____

Patient Signature **Date**

PATIENT NAME: _____

Last First Middle Initial Date of Birth