SunCoast Pain Management

Patient Name: _____ **Date:** _____

Where is the pain located?	**Head**	**Spine**	**Arms**	**Legs**							
ANALGESIA											
Pain Level today?	0	1	2	3	4	5	6	7	8	9	10
Least Pain Level in last week?	0	1	2	3	4	5	6	7	8	9	10
Most Pain Level in last week?	0	1	2	3	4	5	6	7	8	9	10
% relief since last visit	<25%	25%	50%	75%	100%						
ACTIVITIES OF DAILY LIVING											
% more active since last visit	<25%	25%	50%	75%	100%						
Have you been exercising?											
Walking	Yes	No									
Running	Yes	No									
Bicycling	Yes	No									
Weight training	Yes	No									
Swimming	Yes	No									
Other	Yes	No									
Mood	Better	Same	Worse								
Family Relationships	Better	Same	Worse								
Social Relationships	Better	Same	Worse								
Overall Functioning	Better	Same	Worse								
Sleep Patterns	Better	Same	Worse								
How many hours sleep per night?	2	4	6	8	10	>10					
ADVERSE EFFECTS											
Constipation	Yes	No									
Drowsiness	Yes	No									
Fatigue	Yes	No									
Itching	Yes	No									
Mental Cloudiness	Yes	No									
Nausea	Yes	No									
ABERRANT BEHAVIOR											
Pain Meds from other Providers since last visit?	Yes	No									
Taken any illegal drugs since last visit?	Yes	No									
Consume Alcohol since last visit?	Yes	No									
Last time took Pain Medication? (Hrs)	<2	2-4	4-6	6-8	8-10	10-12	>12				

Current Address:

Current Insurance:

Current Medications: