



0900000

PLACE LABEL HERE.
IF LABEL NOT AVAILABLE, WRITE IN PT NAME & MR#

ACUTE PAIN SERVICE — PROGRESS NOTE - PSYCHOLOGY

History Obtained From: Patient Past chart Current Chart Other _____ Room # _____
Patient Presentation: Alert Oriented Somnolent Affect: _____

Chief Complaint/Pain Location:

Medications/Issues:

Patient's Current Pain Rating 0-1-2-3-4-5-6-7-8-9-10 No Pain Worst possible Pain
Average Pain Over Past 24 Hours 0-1-2-3-4-5-6-7-8-9-10 No Pain Worst possible Pain
Patient's Comfort Goal 0-1-2-3-4-5-6-7-8-9-10 No Pain Worst possible Pain
Duration Of Pain: Constant Intermittent Episodic
Onset of Pain: At Rest With Activity Sudden
Quality of Pain: Aching Burning Sharp
Associated Symptoms: Current Anxiety: 0-1-2-3-4-5-6-7-8-9-10 No Anxiety Worst possible Anxiety
Quality of Sleep 0-1-2-3-4-5-6-7-8-9-10 Best Sleep Worst Possible
Activity Interference from Pain: Yes No

Current Psychological Treatment for Pain: Cognitive-behavioral Education Self-management Training
 Supportive Team/Staff Education or Collaboration

Issues Addressed and Response to Intervention:

Plan/Recommendations: APS MD Recommended (PIC 1415) Recommended titration schedule D/C planning
PMC Follow up: Pain Psychology Pain MD (For Scheduling Info 4-8642 or 3-5676)

Axis I:
Axis II:
Axis III:

Fellow Signature: _____ Date: _____ Time: _____ to _____ PIC: _____

Patient satisfaction with pain management 0-1-2-3-4-5-6-7-8-9-10 Completely Dissatisfied Completely Satisfied
Perceived Effectiveness of pain management regimen 0-1-2-3-4-5-6-7-8-9-10 Not effective Completely Effective

Attending Additional Findings or Comments:

I have reviewed and edited Dr. _____'s note above and agree with his/her treatment, impressions and recommendations.

Attending Signature: _____ Date: _____ Time: _____ to _____ PIC: _____