Date:____/____/____

# PROGRESS NOTE
## PAIN ASSESSMENT AND DOCUMENTATION TOOL (PADT)

**Patient Name:**________________________ **Pain Level (0-10): 0 1 2 3 4 5 6 7 8 9 10**

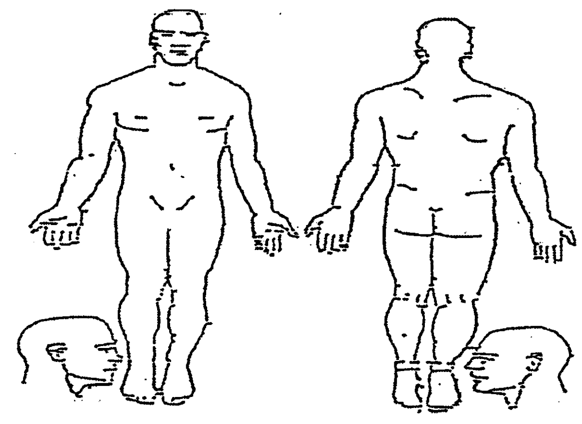
**Chief Complaint**:__________________________________________________

**Pharmacy Name** ____________________
**Recent MRI/CT/X Ray Yes / No if yes give report and CD/Films to receptionist**
**Auto/Work Comp Related Yes/ No**
**Address/Phone/Insurance Changes Yes / No**

| **Current Pain Medication** | **Strength** | **Frequency** | **Recent Pain Procedures/Dates:** |
|---|---|---|---|
| | | | |
| | | | |

**Patient's Signature:**______________________________

Please shade area where your pain is located on the diagram below.



### Analgesia

If zero indicates "no pain" and ten indicates, "pain as bad as it can be," on a scale of 0 to 10, what is your level of pain for the following questions?

1. What was your pain level on average during the past week? **(Please circle appropriate number)**

**No Pain** 0 1 2 3 4 5 6 7 8 9 10 **pain as bad as it can be**

2. What was your pain level at its worst during the past week?

**No Pain** 0 1 2 3 4 5 6 7 8 9 10 **pain as bad as it can be**

3. What percentage of your pain has been relieved with your medications during the past week? (Write in a percentage between 0% and 100%)________________________

4. Is the amount of pain relief you are now obtaining from your current pain reliever(s) enough to make a real difference in your life? __Yes No__

### Activities of Daily Living

Please indicate whether you are functioning with your current pain relievers is **Better**, the **Same**, or **Worse** since last visit/assessment. **(Circle answer below)**

| | | | | |
|---|---|---|---|---|
| 1. | Physical functioning | Better | Same | Worse |
| 2. | Family relationships | Better | Same | Worse |
| 3. | Social relationships | Better | Same | Worse |
| 4. | Mood | Better | Same | Worse |
| 5. | Sleep patterns | Better | Same | Worse |
| 6. | Overall functioning | Better | Same | Worse |

### Adverse Effects

Are you experiencing any side effects from current pain reliever? **(Circle answer below)**

| | | | | |
|---|---|---|---|---|
| **Nausea** | None | Mild | Moderate | Severe |
| **Vomiting** | None | Mild | Moderate | Severe |
| **Constipation** | None | Mild | Moderate | Severe |
| **Itching** | None | Mild | Moderate | Severe |
| **Mental Cloudiness** | None | Mild | Moderate | Severe |
| **Sweating** | None | Mild | Moderate | Severe |
| **Fatigue** | None | Mild | Moderate | Severe |
| **Drowsiness** | None | Mild | Moderate | Severe |
| **Other** ____ | None | Mild | Moderate | Severe |
| **Other** ____ | None | Mild | Moderate | Severe |