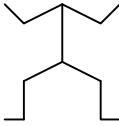


Pain – History & Physical Findings

		Name _____	
Date _____	Pain Disability (3=lot) Walking _____ Pleasure act. _____ Shopping _____ Driving _____ Exercise _____ Bathing _____ Toilet/cont. _____ Thinking _____ Sleep _____ Appetite _____ Mood _____ Relationships _____ Energy _____ Total (0-39) _____	Pain Hx (onset, locations, descriptors, worse/better, treatments)	ROS (circle positives) Vision/hearing Lo energy Sleepy Dizzy/unsteady Syncope Falls Dry mouth Chest pain Ulcer/GERD Constipation Nausea Appetite Weight change Edema Night sweats Insomnia Depression Urine freq. Confusion Sex dysfxn
Age _____			
PMHX (circle positives) Headache TMJ Dental Neck pain Dysphagia COPD Chest pain Cardiac problem GI problem GU problem Abdominal pain Pelvic/GU pain Arthritis Fibromyalgia Joint pain Back pain Hip/knee pain Muscle pain Diabetes Neurologic disorder Depression Anxiety Sleep problems		Medications	Exercise History Min/wk _____ What kind? _____
Family History (circle positives) Diabetes Arthritis Depression Anxiety Neurologic disorder			

Pain – History & Physical Findings

Vital Signs	BP _____	P _____	T _____	Wt. _____	lb _____	Ht. _____	in _____
Eyes <input type="checkbox"/> nl conjunctiva & lids Pupils <input type="checkbox"/> pupils symmetrical, reactive Fundus <input type="checkbox"/> nl discs & pos elements Vision <input type="checkbox"/> acuity and gross fields intact			MS Gait <input type="checkbox"/> nl Get Up and Go Test Extremities <input type="checkbox"/> no edema Check nl, circ abn ROM Strength Tone Sensory Right arm <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Left arm <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Right leg <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Left leg <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> Spine/back <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>				
ENT-External <input type="checkbox"/> no scars, lesions, masses Otoscope <input type="checkbox"/> nl canals & tympanic membranes Hearing <input type="checkbox"/> nl to _____ Intranasal <input type="checkbox"/> nl mucosa, septum, turbinate Ant. Oral <input type="checkbox"/> nl lips, teeth, gums Oropharynx <input type="checkbox"/> nl tongue, palate, pharynx			Cognition <input type="checkbox"/> normal screen. Test: _____ Attention <input type="checkbox"/> nl alertness, attentive Cranial nerves <input type="checkbox"/> w/o gross deficit Coordination <input type="checkbox"/> nl rapid alternating movement DTR's <input type="checkbox"/> symmetrical, ____ (scale: 0-4+) Sensation <input type="checkbox"/> nl touch, proprioception Mood <input type="checkbox"/> nl screen. GDS____/15				
Neck palp. <input type="checkbox"/> symmetrical without masses Thyroid <input type="checkbox"/> no enlargement or tenderness JVD <input type="checkbox"/> None .v-srodiac			Resp. effort <input type="checkbox"/> nl without retractions Chest percuss. <input type="checkbox"/> no dullness or hyperresonance Chest palp. <input type="checkbox"/> no fremitus Auscultation <input type="checkbox"/> nl bilateral breath sounds w/o rales				
Heart palp. <input type="checkbox"/> nl location, size Cardiac ausc. <input type="checkbox"/> no murmur, gallop, or rub Carotids <input type="checkbox"/> nl intensity w/o bruit Pedal pulses <input type="checkbox"/> nl posterior tibial & dorsalis pedis			Breasts <input type="checkbox"/> nl inspection & palpation Abdomen <input type="checkbox"/> no masses or tenderness L/S <input type="checkbox"/> no liver/spleen enlargement Hernia <input type="checkbox"/> no hernia identified Anus/rectal <input type="checkbox"/> no abnormality or masses	Pain Body Area: _____ Inspection: Palpation: Strength: Sensation: Function:			
GU male <input type="checkbox"/> nl inspection & palpation Prostate <input type="checkbox"/> nl size w/o nodularity GU female <input type="checkbox"/> external genitalia nl w/o lesions Int. inspection <input type="checkbox"/> nl bladder, urethra, & vagina Cervix <input type="checkbox"/> nl appearance w/o discharge Uterus <input type="checkbox"/> nl size, position, w/o tenderness Adnexa <input type="checkbox"/> no masses or tenderness			Lymphatic <input type="checkbox"/> nl neck & axillae Lymph other <input type="checkbox"/>	Pain Body Area: _____ Inspection: Palpation: Strength: Sensation: Function:			

Pain – History & Physical Findings

Additional Description of Positive Findings

Assessment

Plan

- Educational Materials**
- (check those given)*
- Evaluation and Management of Persistent Pain
 - How to Complete the Daily Pain Diary
 - Using Medications for Persistent Pain
 - Living Well with Persistent Pain
 - Exercising with Persistent Pain
 - How to Stretch
 - NSAIDs
 - Opioids and Persistent Pain
 - Depression Medications for Persistent Pain
 - Managing Constipation
 - Treating Pain without Pain Pills