Pain Management Treatment

PATIENT INFORMATION

Name: _____ Date of birth: _____ dd / mm / yyyy

Gender: _____ Date of assessment: _____ dd / mm / yyyy

Medical history:

Primary care physician: _____

Insurance information:

PAIN ASSESSMENT

Type of pain: _____ Location of pain: _____

Severity of pain: _____ Duration of pain: _____

TREATMENT PLAN

I. Medications

a. Pain relievers:

b. Nerve pain medications:

c. Other medications:

II. Therapy

a. Physical therapy:

b. Occupational therapy:

c. Psychological therapy:

LIFESTYLE MODIFICATIONS

I. Exercise:

II. Dietary changes:

III. Stress management:

INTERVENTIONS

I. Nerve blocks:

II. Epidural injections:

III. Other procedures:

FOLLOW-UP PLAN

Next appointment: _____ dd / mm / yyyy

Monitoring symptoms:

HEALTHCARE PROFESSIONAL INFORMATION

Name: _____ License ID: _____

Signature:

Date: _____ dd / mm / yyyy