MEDICATION / PAIN ASSESSMENT

Patient Name: ______________________________ Account # ____________________

Diagnosis : ________________________________ Date: _____________________

Verification of Medications

Name of Medication	Dosage	Amount	How Often
1			
2			
3			
4			
5			
6			
7			

Over the Counter Medications (check all you take regularly)

- ☐ Aspirin/Ibuprofen
- ☐ Cold Medicine
- ☐ Laxative
- ☐ Other ____________________
- ☐ Antacids
- ☐ Cough Medicine
- ☐ Diet Pills
- ☐ Other ____________________
- ☐ Sleeping aids
- ☐ Allergy Relief
- ☐ Vitamin/Herbal supplements

Pain Drawing

PLEASE COMPLETE THIS PAIN DRAWING SO

WE CAN UNDERSTAND THE LOCATION AND INTENSITY OF YOUR PAIN.

Instructions: Mark these drawings according to where you hurt (if the right side of your neck hurts, mark the drawing on the right side of the neck, etc.). Please indicate which sensations you feel by referring to the key below.

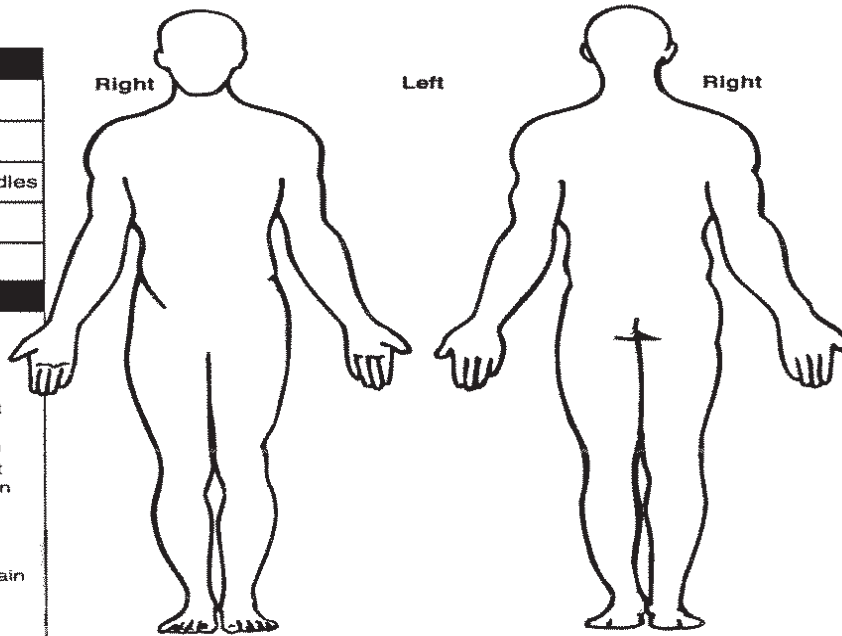
☐ RIGHT HANDED

☐ LEFT HANDED

KEY	
//////	Stabbing
XXXX	Burning
0000	Pins & Needles
====	Numbness
++++	Aching

PAIN LEVEL

- 0 No pain
- 1 Mild pain; you are aware of it but it doesn't bother you
- 2 Moderate pain that you can tolerate without medication
- 3 Moderate pain that requires medication to tolerate
- 4-5 More severe pain;
- 6 Severe pain
- 7-9 Intensely severe pain
- 10 Most severe pain;



CIRCLE YOUR CURRENT PAIN LEVEL

0 1 2 3 4 5 6 7 8 9 10

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Patient Signature

______________________________ ____________________
Evaluating Therapist Name: Date