

Patient Pain Assessment and Management Form

Instructions: Complete this form to assess, document, and manage the patient's pain. This form is formatted for printing and manual entry.

1. Patient Information

Patient Full Name:	<input type="text"/>	Date of Birth:	<input type="text"/>
Medical Record Number (MRN):	<input type="text"/>	Date of Assessment:	<input type="text"/>

2. Pain Assessment

Primary Location of Pain:	<input type="text"/>		
Pain Intensity Score (Current, 0-10):	<input type="text"/>	Pain Intensity Score (Best in last 24h, 0-10):	<input type="text"/>
Pain Intensity Score (Worst in last 24h, 0-10):	<input type="text"/>	Acceptable Pain Level Goal (0-10):	<input type="text"/>
Pain Onset and Frequency (e.g., constant, intermittent, sudden):	<input type="text"/>		
Pain Character / Quality (e.g., sharp, dull, throbbing, burning, aching):	<input type="text"/>		
Aggravating Factors (what makes the pain worse):	<input type="text"/>		
Alleviating Factors (what makes the pain better):	<input type="text"/>		

3. Current Pain Management and Effectiveness

Current Pain Medications (Name, Dose, Frequency):	<input type="text"/>
Non-Pharmacological Interventions Used (e.g., ice, heat, physical therapy):	<input type="text"/>
Effectiveness of Current Interventions (e.g., none, partial, complete relief):	<input type="text"/>
Side Effects Experienced (e.g., nausea, constipation, drowsiness):	<input type="text"/>

4. Pain Management Plan

Pharmacological Interventions Planned (Medication, Dosage, Route, Frequency):	<input type="text"/>
Non-Pharmacological Interventions Planned:	<input type="text"/>
Patient Education Provided (e.g., medication safety, pain scale usage):	<input type="text"/>
Follow-up and Reassessment Plan (When/How):	<input type="text"/>

5. Signatures and Verification

Patient Signature (or Representative):	<input type="text"/>	Date/Time:	<input type="text"/>
Clinician Name and Title:	<input type="text"/>	Clinician Signature:	<input type="text"/>