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a patient care clinic
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San Gabriel Valley Intractable Pain Network Member

Periodic Review and Treatment Plan

Patient Name____Date of Birth___/___/___ Today's Date___/___/___

Address____City___________________State_______Zip___________

Accompanied by ____Relationship_________________________________

Home Phone___________________ Cell Phone____________________ E-Mail___________________________________

*****Please bring ALL medications with you to clinic visits*****

List medications and supplements you are taking FROM THIS CLINIC

Medication Name	Pill/Dose Strength	Number taken at a time	Number of **times** taken per day (24 hours)	Number of **tablets** taken per day (24 hours)	Total # needed for a 30 day supply	Notes: For provider use only	Provider Initials

I certify that the information provided is this report is correct and factual the best of my knowledge. I, the patient, recognize and acknowledge the written notes made by Dr. Guess are the results of information I provided, and were recorded in my presence during our face-to-face visit. In addition to any objectives noted above, the goal of this visit is to achieve the best pain control for maximum daily functioning with, or without, opioid medications without my being toxic nor intoxicated. I declare that my current medications and dosages, including my stated needs today, are used tor therapeutic proposes and that I do not misuse, overuse, sell nor trade them. I authorize Dr. Guess to provide a copy of this periodic review to my primary care of family physician.

Patient signature____Date____/____/____

Provider signature____Date____/____/____

Name____________
Date____________

List ALL medications you take that are prescribed by OTHER providers (PCP, and other specialists)

Medication Name	Directions for use	Quantity	Provider

Treatment Objectives

Did you reach last month's 30-day goal? If not why not, and what would aid you in reaching that goal this month?____

____

List a NEW activity to achieve in the next 30 days____.

List a continuing activity over the last 3 months____.

List a LONG TERM goal you wish to achieve in the next year (you must choose a goal every January)

____

____

What tools or therapies to you need to achieve these goals?____________________________________

____

Name____________
Date____________

Side Effects of Medications

	Yes	No
Are you having side effects from your medication?		
Do you feel your medications impair your driving ability?		
Has ANYONE commented on your ability to drive safely?		

If you answered yes to any of the above questions, please describe and inform the provider/staff today.

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____

____

Family Relations

Have family or friends commented on undesirable changes or impairments in you?	Yes	No
Slurred Speech		
Falling Sleep		
Memory Loss		
Inappropriate Drowsiness		
Forgetfulness		
Driving		
Other (list)		

Pain Control

Have you been to an Emergency Room or Urgent Care for ACUTE pain since your last visit? If YES where?	
What do you do when your pain worsens or you experience "break through" pain?	
How many days of the last month have you considered pain free?	
Did you have any pain free hours while awake in the last month?	

Name____________
Date____________

Where are your painful spots today?	Left Side	Right Side
Neck		
Shoulders		
Upper Back		
Lower Back		
Upper Buttock		
Lower Buttock		
Head		
Arms		
Legs		
Feet		
Hands		
Other (describe)		

Pain, Enjoyment, and General Activity (PEG) Scale

Please draw a vertical mark (I) on the line below to describe your *pain average,* in the past week

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst pain imaginable

Please mark on the next line to describe how pain has interfered with your *enjoyment of life* during the last week.

No Interference 0 1 2 3 4 5 6 7 8 9 10 Complete interference

Please mark the next line to describe how pain has interfered with your *general activity* during the last week.

No Interference 0 1 2 3 4 5 6 7 8 9 10 Complete interference

Activities

How many hours in the past month…	Number of Hours	Describe your activity
Were you gainfully employed?		
Did you participate in volunteer activities?		
Did you participate in a hobby?		
Did you spend time caring for a pet?		
Did you look for work?		
Did your care for children?		
Did you spend time writing to friends or family?		
Spend time reading?		
Spend time online/computing?		
Spend time learning something new?		

Name____________
Date____________

Did you get up, get dressed, and go outside of the house EVERY DAY last month? Yes_____ No______

If NO, why not?____

How many times in the past month did you…	
Visit relatives or neighbors?	
Attend church or religious services?	
Shop?	
Work?	
Volunteer somewhere?	

Sleep

How many hours do you consecutively sleep, once you fall asleep?	
Do you have trouble falling asleep?	
Do you have trouble remaining asleep?	
Do you wake up in pain?	
What sleep medication, if any, do you take (include OTC and herbal)?	

Bed/Couch Bound

How many days were you bed-bound last month?	
How many days were you couch-bound last month?	
When you are bed or couch bound who cares for your personal needs?	

Stretching Exercises

Describe the specific exercises you have done in the last month?	
How many days did you stretch and/or exercise last month and how many minutes?	

Weight Control

In the last month, did you gain weight; stay the same, or loose weight?	
Was your weight change (if any) planned or a result of your medical condition?	

Name____________
Date____________

Quality of Life

	Yes	No
Do you consider your pain to be permanent and incurable?		
Do you believe you still require opioids to control your pain?		
Do you believe that your quality of life has improved since you began opioid therapy?		
Do you wish to remain in our intractable pain program and agree to follow all of its rules and requirements?		
Do you wish to stop your treatment with opioids? And begin a "taper off" program or be given "withdrawal medications"?		

What are the improvements that intractable pain treatment has provided to you (check all that apply)	
Less intractable pain	
More movement	
Fewer suicide thoughts	
Less depression	
Able to work/volunteer	
Better family life	
Improved intimacy with my spouse	
Other (explain)	

Describe in own words what you will do to improve your quality of life in the next 30 days________________

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