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PATIENT ACCOUNT OF PROGRESS OF CHRONIC PAIN MANAGEMENT (FOLLOW UP)

Dear patient, it is our every intention to ensure that your pain treatment is not only effective but that you yourself see the benefits of your treatment. In addition, we must make every effort to help educate you on all aspects of your treatment. This includes patient education on the actual disorder as well as the benefits AND RISKS of the medications

DISORDER/PATIENT EDUCATION/UNDERSTANDING OF MEDICATIONS (BENEFITS/RISKS)

-Which pain related disorders are we treating for you?

-Do you understand that the medications you are on may be an opiate or opiate like medication (even buprenorphine) and that you will still be dependent on them just like other opiates?

-Do you understand that it is the purpose of our treatment to improve pain management but not necessarily to eliminate all pain and that pain may be a permanent part of your life?

PATIENT & FAMILY EDUCATION

-How have Dr Edrich and his staff helped educate you and your family on your condition and the risks/benefits of the medications prescribed?

-Do you feel you have a "complete and full" understanding of your condition and the meds involved?

-Do you understand that it is your right (and we encourage this) to consult with any other physician on your disorder so that you, the patient, may be as educated and reassured as possible. We will always be more than happy to refer you to any other provider.

DISORDER WORKUP & SPECIALIST EVALUATIONS

-List the specialists you have seen over the last year and what they said were any other treatment options?

-List any physical or occupational therapists or acupuncturists you have seen and if it helped.

-List any psychologists you have seen over the past year?

-Have you been told that psychologists are often very effective and helping reduce pain perception by using specific cognitive techniques. Its a rather new thing but we strongly encourage their use. If you have not seen one, would you be willing to do so?

CLINICAL RESPONSE TO TREATMENTS:

Rate your pain level now compared to past:
-**before ever** coming to our practice your pain was at what level? _____/10 (10= theworst)
-**Now,** where would you rate your pain on average? _____/10 (10=the worst)

- how do you feel progress has gone over the past year? Have you made improvements? Gotten worse?

-for each item below put down: **"MUCH BETTER, BETTER, SAME, WORSE"**
If worse pls explain
*physical functioning?
*family relationships?
*Social relationships?
*Mood?
*Sleep patterns?
*Overall functioning

SIDE EFFECT AND FUNCTIONING:

-write down any medication side effects and explain:
*Nausea?
*Vomiting?
*Constipation?

*Itching?
*Mental Cloudiness?
*Sweating?
*Fatigue?
*Drowsiness?

MEDICATION SAFETY & PAIN MEDICATION RISKS:

-Have you ever found yourself sedated from your meds?

-Do you suffer from a condition called "sleep apnea"?

-Have your moods ever gotten worse since our treatment began?

-Do you ever drink alcohol or smoke weed? (you must explain how much)

-Have you been reminded that alcohol is never ever to be consumed while under our care and while on any opiates?

-When was the last time you were involved in an accident (car etc)? Were you taking meds at the time? You MUST fully explain ANY accidents and whether you think medications were a contributor or not.

-Do you ever change any of our dosing instructions or take the medicine differently than we prescribe it? including over use it??

Do you understand that it is extremely important to never take more or take other controlled medications different from what we prescribe?

-Have you lost or had your medications stolen in the past 6 months?

-Do you keep all of your controlled medications locked up at all times?

-Have you been informed that you may not ever give your medications to any other person (even if they are on the same medications)?

-Have you been made aware that you may purchase a combination lock box from us?

-Have you been told that you may be required to buy one from us if you do not send us pictures / proof that you have your medications locked up at home?

-Are there any infants/children/adolescents or other non family adults living at home with you? Who?

-What occupation do you hold? Have the medications affected your work?

FUTURE PLANNING & SUGGESTIONS

-what would you like to accomplish as a "GOAL" in our treatment? Are there any parts of your treatment that we should more closely discuss or try to resolve?

_____

PATIENT SIGNATURE & DATE