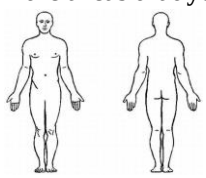
Victory Physicians Family Medicine
Interval Pain Management Questionnaire

Patient Name: _____ **Date:** _____

Interval Pain Assessment

Place an X on the areas that you have pain



1. What diagnosis(ses) are we treating that cause you pain?
2. Is your pain **BETTER**, **WORSE**, or the **SAME** since your last visit?
3. Has your pain changed or moved since the last visit? ◯ YES or ◯ NO
4. What is your **TARGET** pain number on a scale of 0-10 i.e. how low do we have to get you on a scale of 0-10 so you can function adequately? _____/10
5. What was your **AVERAGE** pain number in the interval between your last visit and now? _____/10
6. Is your quality of life better, worse or the same since **STARTING** pain medication, taking into account side effects, cost, efficacy and inconvenience of the pain medications?
7. List functional markers you **HAVE** seen improvement in while on your pain regimen? (from your long form list)
8. List functional markers you **HAVE NOT** seen improvement in while on your pain regimen? (from your long form list)
9. Are you having any side effects of the medicines? ◯ YES or ◯ NO
10. Were there any concerning events that occurred since your last visit? ◯ YES or ◯ NO
11. Do you think you need **SAME, MORE, or LESS** medicine than you are currently receiving?
12. Are you **HAPPY** or **UNHAPPY** with your pain control, overall? If unhappy, why?
13. Have you gotten pain meds from any other source since your last visit? ◯ YES or ◯ NO
14. Did you lose, share or sell your medications since your last visit? ◯ YES or ◯ NO
15. Are there any changes to the last long form pain management questionnaire you filled out that you wish to change, that our physician needs to know about? ◯ YES or ◯ NO
16. Do you want to continue taking pain medications? ◯ YES or ◯ NO Do you want to taper down? ◯ YES or ◯ NO

My signature below confirms that the above statements are true and complete to the best of my knowledge.

_____ _____ _____

Signature Printed Name Date