Victory Physicians Pain Management

Subjective, Objective and Functional Assessments

The American Academy of Family Physicians has finally adopted what has been the standard of care for pain management physicians for quite some time. In keeping with our requirement to meet the standard of care as set by the AAFP, we are providing this sheet which will assist patients in understanding what the subjective, objective and functional assessments are that the physician will be conducting. All patients requesting or receiving ongoing pain management will be required to provide careful and accurate data so that our Medical Director can assess whether starting or continuing pain management is appropriate.

Subjective assessment of a patient's pain includes how the patient characterizes their pain on the history the physician takes and whether or not the patient thinks the medicine(s) is/are working. Objective assessment includes the data the patient provides on a pain log which indicates whether or not pain is increasing, decreasing or remaining unchanged with ongoing treatment.

Functional assessment of pain is done by asking the patient what they would like to physically be able to do or do better if their pain was controlled, prior to starting therapy. As pain medicines are adjusted, the patient provides continual reassessment of their function to see if goals are being met. This is the big change that AAFP has undergone. The AAFP believes that if you are going to be prescribed a side effect ridden medication such as a narcotic whose long term efficacy is murky at best, it better at least be helping a patient meet their functional goals.

On the **initial pain assessment form** and on each p**eriodic interval assessment long form**, Question #16 asks a patient to list 7 things they hope to be able to do once their pain is controlled that they cannot do now or at least cannot do well now. On following visits, the **short periodic interval assessment form** asks a patient in Question #7 and #8 to list which of those seven things listed on the **long form** have improved with treatment and which haven't. To save space, a patient need only list the numbers and not the activity. Example would be Question #7: 1,3,6 and Question #8: 2,4,5,7. All 7 functional activities must be accounted for in your responses. Because you will need to continually refer to the 7 functional activities or markers you listed on your **long form**, patients should retain copies of their long form for future reference so they can answer questions 7 and 8 properly.

Patients are required to take these assessments very seriously. Failure to do so may result in being cited by the Medical Director which can lead to corrective action. This is now the standard of care and no deviation from it will be permitted. If you don't understand something, kindly ask us.