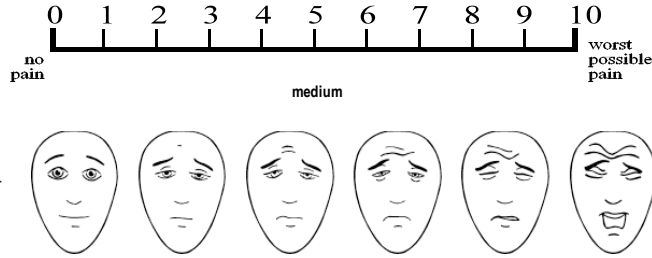
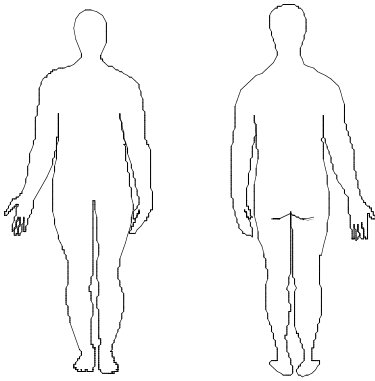


LOCATION
Mark site 1 2 or 3

PAIN FLOWSHEET

Name: _____



- PATIENT'S PAIN CONTROL GOAL**
- Sleep comfortably
 - Comfort at rest
 - Comfort with movement
 - Stay alert
 - Perform activity: _____
 - Other: _____

Neuropathic Pain Screening
(See Pain Assessment Tool)
POSITIVE ___ YES ___ NO

Date: _____ Current Medications for Pain Management _____

Drug/Dose/ Frequency _____ Drug/Dose/ Frequency _____

Drug/Dose/ Frequency _____ Drug/Dose/ Frequency _____

DATE:

Patient's Rating of Pain	Site 1 _____	Site 2 _____	Site 3 _____
Scale used			
<input type="checkbox"/> 0 -10	Present:		
<input type="checkbox"/> Faces	At Worst:		
<input type="checkbox"/> Verbal	At Best:		

Side-effects / Treatment / Changes in Pain Medications or Comments

PRN / Breakthrough Analgesic given _____ : Time : _____ Initials

DATE:

Patient's Rating of Pain	Site 1 _____	Site 2 _____	Site 3 _____
Scale used			
<input type="checkbox"/> 0 -10	Present:		
<input type="checkbox"/> Faces	At Worst:		
<input type="checkbox"/> Verbal	At Best:		

Side-effects / Treatment / Changes in Pain Medications or Comments

PRN / Breakthrough Analgesic given _____ : Time : _____ Initials

DATE:

Patient's Rating of Pain	Site 1 _____	Site 2 _____	Site 3 _____
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<input type="checkbox"/> 0 -10	Present:		
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Side-effects / Treatment / Changes in Pain Medications or Comments

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			Initials
PRN / Breakthrough Analgesic given		: Time :	Initials

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