

Pain Management Treatment

Patient information	
Name:	Date of birth:
Gender:	Date of assessment:
Medical history:	
Primary care physician:	
Insurance information (if applicable):	
Pain assessment	
Type of pain:	
Location of pain:	
Severity of pain:	
Duration of pain:	
Treatment plan	
I. Medications	II. Therapy
a. Pain relievers:	a. Physical therapy:
b. Nerve pain medications:	b. Occupational therapy:
c. Other medications:	c. Psychological therapy:

Lifestyle modifications	
I. Exercise:	
II. Dietary changes:	
III. Stress management:	
Interventions	
I. Nerve blocks:	
II. Epidural injections:	
III. Other procedures:	
Follow-up plan	
Next appointment:	
Monitoring symptoms:	
Healthcare professional information	
Name:	License ID:
Signature:	Date: