INTLIFE PAIN MANAGEMENT CIC – REVIEW FORM

MAIN SITE OF PAIN: . . . . . | INTENSITY since last review/1st cons (From 0 -10) . . . . . INTENSITY NOW (From 0 -10) . . . . . MOBILITY

WHAT PRESCRIBED MEDICATIONS HAVE YOU STOPPED OR DECREASED (IF ANY) FOR YOUR CURRENT PAIN?

NAME	PURPOSE	REDUCED	STOPPED
1	. . . . .	. . . . .	. . . . .
2	. . . . .	. . . . .	. . . . .
3	. . . . .	. . . . .	. . . . .
4	. . . . .	. . . . .	. . . . .
5	. . . . .	. . . . .	. . . . .

CAN YOU NOW DO THE MAIN 3 ACTIVITIES THAT YOU COULD NOT DO BEFORE YOU HAD TREATMENT FOR YOUR PAIN?

1) . . . . . YES ❑ NO ❑ A LITTLE ❑

2) . . . . . YES ❑ NO ❑ A LITTLE ❑

3) . . . . . YES ❑ NO ❑ A LITTLE ❑

ARE YOU ABLE TO WORK NOW? (if you could not before) YES ❑ A LITTLE ❑ NO ❑ N/A ❑

HAS YOUR MOOD IMPROVED SINCE YOU STARTED TREATMENT AT THIS CLINIC?
HAVE YOU ACHIEVED WHAT YOU HOPED TO ACHIEVE BY COMING TO THIS CLINIC?
1) . . . . . YES ❑ NO ❑
2) . . . . . YES ❑ NO ❑
3) . . . . . YES ❑ NO ❑
IN YOUR OPINION, HOW MUCH HAS YOUR CONDITION IMPROVED IN TERMS OF PERCENTAGE? . . . . . PERCENT

Please turn sheet over

PLEASE WRITE ANY COMMENTS BELOW (You may include anything at all: service, effectiveness, décor, premises, etc or any suggestions that would help us provide a better service)

. . . . . .

. . . . . .

. . . . . .

. . . . . .

. . . . . .

OUTCOME

	Yes	No
Treatment continued (initial goals)	❑	❑
Treatment continued (new goals)	❑	❑
Treatment completed / Leaver	❑	❑

PATIENT'S SIGNATURE

. . . . . .