CHRONIC PAIN ASSESSMENT AND TREATMENT PLAN

DATE:

check one:
- INITIAL
- PERIODIC REVIEW (at least annual)

Description of Pain Symptoms:

Functional Impact:
- Physical Activities/Mobility:
- Social Functioning:
- Mood:
- Sleep:
- Other:

Diagnostic Studies:

Pharmacologic Treatment:
- Medications:
- Degree of Relief:
- Adverse Events:

Non-pharmacologic Treatment (e.g., PT/OT, acupuncture, mindfulness, consultation, substance use treatment, other):

Relevant co-occurring conditions:

Substance Use History:
- Past:
- Current:

Aberrant Drug-Related Behavior/Agreement Violations History:

Relevant Physical Exam (or see note dated ________):
Assessment:
- Level of Pain Control:
- Functional Status:
- Agreement Violations:

Treatment Goals:
- Analgesia:
- Physical Functioning:
- Social Functioning:
- Mental Health/Substance Use:

Treatment Plan:
- Pharmacologic Therapy:
- Non-pharmacologic Therapy:
- Diagnostic Studies:
- Consultation:

Documentation Checklist:
- Initiation or continuation of prescribed controlled substances for the treatment of this patient’s condition is justified.
- Informed Consent for Long-Term Controlled Substance Therapy for Chronic Pain signed on:
- Patient-Provider Agreement for Long-Term Controlled Substance Therapy for Chronic Pain signed on:
- Medication list in LCR up-to-date with current and discontinued medications noting reasons for changes
- Clinical Alert for controlled substances therapy entered/updated
- Pain Management Registry Code (338.99) entered into LCR problem list

Provider Signature:
CHN #:
Date: