Hartford Hospital
A Hartford HealthCare Partner
Pain Treatment Center

DATE:______________________________

NAME:______________________________

DATE OF BIRTH: ______________________

PROVIDER: __________________________

MEDICAL PROGRESS NOTE

WHAT TYPE OF VISIT ARE YOU HERE FOR TODAY? ❑ FOLLOW UP VISIT ❑ PROCEDURE

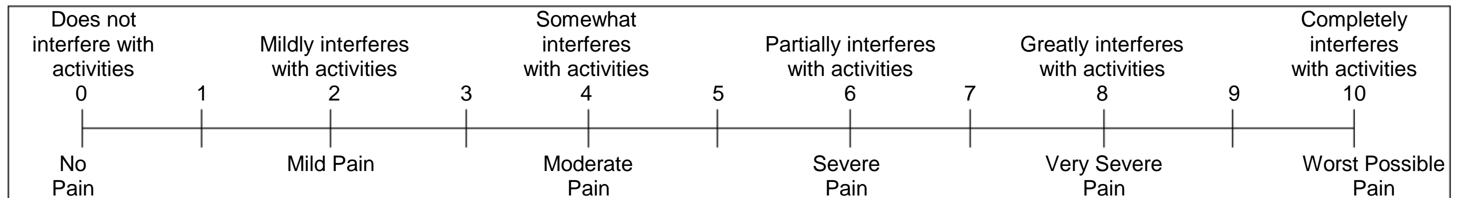
WORKERS COMP PATIENTS ONLY (Please complete this section if you are here for a Workers Comp visit today.)

CURRENT WORK STATUS: ❑Fulltime ❑Part-time (_____ hours/week) ❑Not currently employed ❑Retired

IS YOUR CASE IN DISPUTE? ❑ YES ❑ NO OCCUPATION:_______________________________________

SECTION 1: CURRENT PAIN LEVEL

Using the chart below, answer each question by circling the number that corresponds with your pain level.



PAIN SCALE ⇨	☺	0	1	2	3	4	5	6	7	8	9	10	☹
Current pain level.	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely Interferes
Average pain level since last visit.	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely Interferes
Pain level at its worst.	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely Interferes
Pain level at its least.	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely Interferes
Rate your ability to:													
Sleep	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely Interferes
Manage activities that require standing	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely Interferes
Manage activities that require walking	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely Interferes
Manage activities that require sitting	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely Interferes
Manage your daily responsibilities	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely Interferes
Manage your hobbies and/or recreational activities.	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely Interferes
Choosing one from the following activities, rate your ability to do:_______________	Does Not Interfere	0	1	2	3	4	5	6	7	8	9	10	Completely Interferes

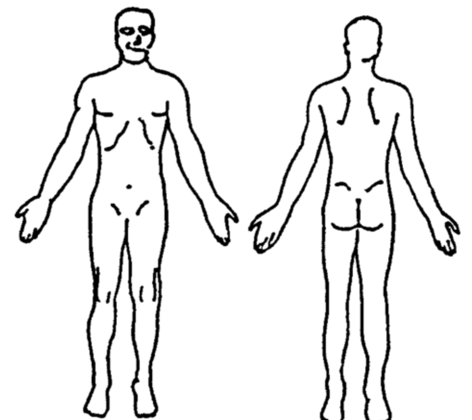
① work ② housework ③ gardening/yard work ④ play with children ⑤ driving ⑥ exercise ⑦ sports/golf ⑧ intimacy

WORK STATUS (if not Workers Comp): ❑Full Time ❑Part Time (___hrs/wk) ❑Not currently employed ❑Retired ❑Disability

OCCUPATION: ____

WHERE IS YOUR PAIN PRIMARILY LOCATED? (Please ☑ below & shade on diagram.)

❑ Head ❑ Neck ❑ Upper-Mid Back
❑ Right Arm ❑ Left Arm ❑ Mid-Back Pain
❑ Lower Back ❑ Abdomen ❑ Pain in the Tailbone
❑ Other:____



HOW WOULD YOU DESCRIBE YOUR PAIN? (Please ☑ below all that apply.)

❑ Burning ❑ Shooting ❑ Throbbing
❑ Cramping ❑ Aching ❑ Constant
❑ Sharp ❑ Dull ❑ Intermittent
❑ Other: ____

SECTION 1: CURRENT PAIN LEVEL (continued)

PAIN INCREASES WITH: ❑ Walking ❑ Sitting ❑ Standing ❑ Activity ❑ Other:______________

PAIN DECREASES WITH: ❑ Rest ❑ Lying Down ❑ Heat ❑ Cold ❑ Other:______________

DO YOU USE ANY ASSISTIVE DEVICES? ❑ None ❑ Wheelchair ❑ Cane ❑ Walker ❑ Crutches ❑ Prosthesis ❑ Other

IS YOUR PAIN LEVEL BETTER SINCE YOUR LAST VISIT? ❑ Yes ❑ No ❑ Same

IF YOU HAD AN INJECTION ON YOUR LAST VISIT, DID IT DECREASE YOUR PAIN? ❑ 0% ❑ 25% ❑ 50% ❑75% ❑ More than 75%

HOW WELL DO YOU SLEEP? ❑ 0-4 hrs/night ❑ 4-6 hrs/night ❑ 6-8 hrs/night ❑ Restful ❑ Disruptive ❑ Pain Related

HAVE YOU HAD ANY NEW SIDE EFFECTS? (If yes, please specify) ______________________

SECTION 2: CURRENT SYMPTOMS (Please indicate Yes or No for each symptom.)

Constitutional

Y N Fever	Y N Feeling Weak	Y N Recent Weight Gain (___ Lbs)
Y N Chills	Y N Feeling Tired (Fatigue)	Y N Recent Weight Loss (___ Lbs)
Y N Feeling Poorly (Malaise)	Y N Change In Appetite	

Eyes

Y N Vision Loss	Y N Eye Pain	Y N Discharge From Eyes
Y N Blurred Vision	Y N Dry Eyes	

ENT

Y N Earache	Y N Nosebleeds	Y N Sore Throat
Y N Loss of Hearing	Y N Nasal Discharge	Y N Hoarseness
Y N Post Nasal Drip	Y N *Sinus Stuffiness*	Y N *Difficulty Swallowing*

Cardiovascular

Y N Chest Pain	Y N Heart Rate is Slow	Y N Lower Extremity Swelling (Edema)
Y N Palpitations	Y N Leg Pain w/Exercise (Leg Claudication)	
Y N Heart Rate is Fast		

Respiratory

Y N Shortness of Breath	Y N Cough	Y N Short of Breath on Exertion
Y N Wheezing	Y N Cough Worse at Night	Y N Need pillows to breathe (Orthopnea)

Gastrointestinal

Y N Abdominal Pain	Y N Vomiting	Y N Bloody Stools
Y N Constipation	Y N Diarrhea	Y N Heartburn/Acid Reflux
Y N Nausea		

Genitourinary

Y N Painful Urination (Dysuria)	Y N Incontinence	Y N Frequency
Y N Urinary Retention	Y N Urination Hesitancy	Y N Pelvic Pain
Y N Vaginal Discharge	Y N Abnormal Vaginal Bleeding	Y N Menstrual Pain (Dysmenorrhea)
Y N Genital Lesion	Y N Inadequate Penile Erection	

(CONTINUED ON NEXT PAGE)

SECTION 2: CURRENT SYMPTOMS (CONTINUED) (Please indicate Yes or No for each symptom.)

Musculoskeletal

Y	N	Joint Pain (Arthralgias)	Y	N	Neck Pain	Y	N	Limb Pain
Y	N	Muscle Pain (Myalgias)	Y	N	Joint Swelling	Y	N	Limb Swelling
Y	N	Back Pain	Y	N	Joint Stiffness			

Integumentary

Y	N	Skin Rash	Y	N	Itching (Pruritus)	Y	N	Hair Loss
Y	N	Hives	Y	N	Dry Skin	Y	N	Skin Wound(s)

Neurological

Y	N	Headache	Y	N	Numbness	Y	N	Fainting
Y	N	Confusion	Y	N	Tingling	Y	N	Limb Weakness
Y	N	Convulsions	Y	N	Tremor	Y	N	Difficulty Walking
Y	N	Significant Head Injury	Y	N	Dizziness	Y	N	Balance Impaired
Y	N	Memory Lapses/Loss	Y	N	Excessive Sleepiness During the Day (Daytime Somnolence)			

Psychiatric

Y	N	Suicidal	Y	N	Anxiety	Y	N	Depression
Y	N	Sleep Disturbances	Y	N	Crying Spells	Y	N	Emotional Problems

Endocrine

Y	N	Hot Flashes	Y	N	Deepening of the Voice
Y	N	Excessive Sweating	Y	N	Excessive Thirst (Polydipsia)

Heme/Lymph

Y	N	Swollen Glands	Y	N	Easy Bruising

SECTION 3: CHANGES IN MEDICATIONS (Please list any changes in your medications since your last visit.)

MEDICATIONS	DATE	MEDICATIONS	DATE

SECTION 4: PROCEDURES (If you are having a procedure today, please indicate yes or no to the following questions.)

Y	N	
○	○	Do you have any **active infections** or are you on **antibiotics** at this time?
○	○	Are you **pregnant**?
○	○	Are you **allergic** to **shellfish** or **IV contrast**?
○	○	Are you a **diabetic**?
○	○	Are you taking any **anticoagulants** (blood thinners), such as Aspirin, Coumadin, fish oil, etc.?