

Medication and Pain Sheet

What medications are you taking now?

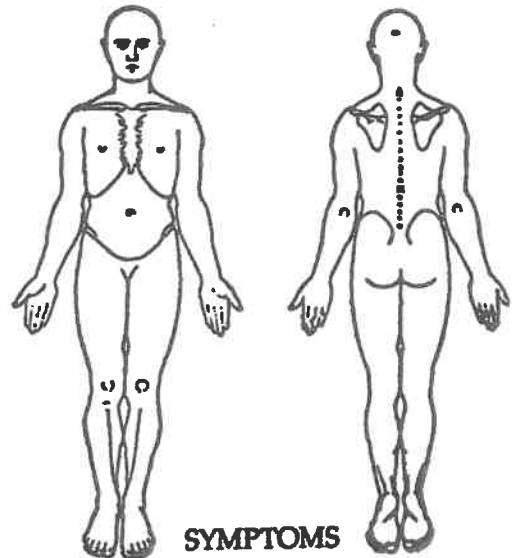
(Including prescription and over-the-counter drugs, herbals, vitamin/mineral/dietary (nutritional) supplements. How your meds are taken? Orally, IM, topical etc.)

- See Attached Med list and dosages
- I will bring a list to my next appointment

Medication	Dosage (How much)	Frequency (How often)	How are your meds taken (Orally, IM, Topical etc.)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

• Rate your pain today and locate it on the diagram:

	10- Being the worst
	0- No pain at all



- **Date of injury/ surgery:** _____ **If not an injury, date symptoms worsened:** _____
- **Does a nurse visit your home for any reason?** _____
- **Have you had any outpatient PT or rehab services this year?** _____
- **Date of next MD appointment:** _____

I verify the medications and dosages are correct to the best of my ability

Signature

Date