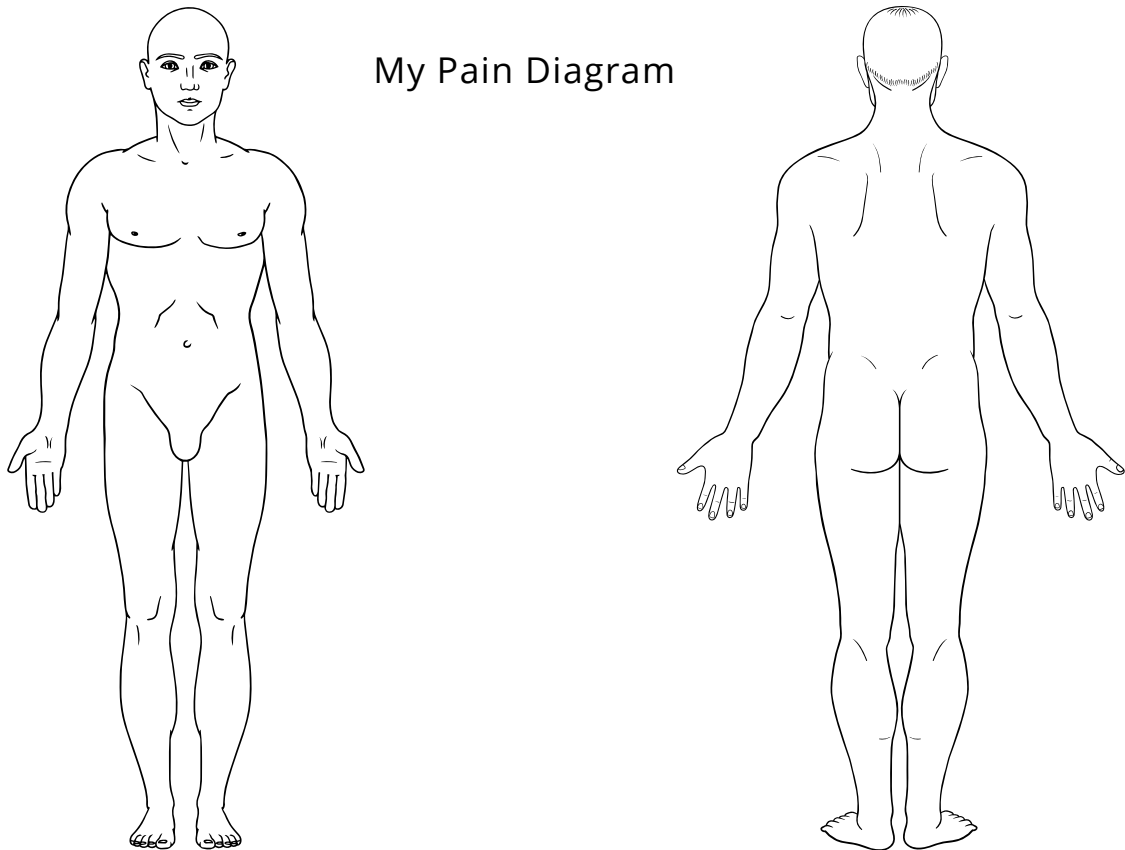




Have you tried any lifestyle changes such as smoking cessation, alcohol reduction/abstinence, dietary changes, or exercise? (Specify which measures, their duration and success)


Can you indicate the areas or regions of pain on your body, **where would they be and what would it look like?**

Please shade areas of pain (may use colours to indicate intensity/sensation, or drawings such as needles, flames or arrows etc.)



**PHARMACY USE ONLY**

Pharmacist to attach any medication list collected from patient (including Rx, OTC, supplements). If possible indicate which pain medications have HELPED.

Indicate therapeutic goals from his assessment, including any recommendations and follow up timelines:


Patient Signature:		Pharmacist Signature:	
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Date:	
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