Pain Management Care Plan

Date: _____

Patient Information

Name: _____

Date of Birth: _____

Medical Record Number: _____

Diagnosis

Primary Diagnosis: _____

Secondary Diagnoses: _____

Pain Assessment

Pain Level (0-10 scale): _____

Location: _____

Duration: _____

Aggravating Factors: _____

Alleviating Factors: _____

Goals of Treatment

- Goal 1: _____
- Goal 2: _____
- Goal 3: _____

Proposed Interventions

- Medication Management: _____
- Physical Therapy: _____
- Cognitive Behavioral Therapy: _____
- Other: _____

Follow-Up Plan

Next Appointment: _____

Referral to Specialist: _____

Provider Signature

_____

Provider Name: _____

Date: _____