Telehealth Chronic Pain Assessment

Date: _____

Patient Name: _____

Patient ID: _____

Provider Name: _____

Provider Contact Information: _____

Patient Medical History

1. Primary Pain Condition: _____

2. Duration of Pain: _____

3. Previous Treatments and Outcomes: _____

4. Current Medications: _____

Pain Assessment

1. Pain Scale (0-10): _____

2. Pain Location: _____

3. Pain Characteristics (e.g., sharp, dull): _____

4. Factors that Aggravate Pain: _____

5. Factors that Alleviate Pain: _____

Functional Assessment

1. Daily Activities Affected: _____

2. Impact on Sleep: _____

3. Impact on Mood: _____

Goals of Treatment

1. Short-Term Goals: _____

2. Long-Term Goals: _____

Plan of Care

1. Recommended Treatments: _____

2. Follow-Up Appointment: _____

Thank you for your participation in this telehealth assessment.

Best Regards,

_____

Provider's Signature