

Chronic Pain Improvement Tracking

Date: **[Date]**

Patient Name: **[Patient Name]**

Physician Name: **[Physician Name]**

Medical Record Number: **[MRN]**

Current Pain Assessment

Location of Pain: **[Specify Location]**

Pain Level (0-10): **[Current Pain Level]**

Duration of Pain: **[Duration]**

Type of Pain: **[Type (Sharp, Dull, etc.)]**

Previous Pain Assessment

Previous Pain Level (Date: **[Previous Date]**): **[Previous Pain Level]**

Treatment Overview

Treatment Plan: **[Current Treatment Plan]**

Medications: **[Medications]**

Physical Therapy: **[Yes/No]**

Improvements Noted

[List any improvements such as reduced pain levels, increased mobility, etc.]

Next Steps

Follow-Up Appointment: **[Next Appointment Date]**

Additional Recommendations: **[Any additional recommendations]**

Sincerely,

[Physician Name]
[Contact Information]