

DATE _____ START TIME _____ END TIME _____ NAME _____

PAIN LEVEL _____ (0-10) PAIN LOCATION _____

PAIN INTERVENTION _____ PAIN MEDS GIVEN _____ DESIRES NO MEDS _____
NURSE CONTACTED _____ REPOSITIONED _____

WHAT BROUGHT YOU TO THE HOSPITAL _____

WHAT IS YOUR GOAL WHILE YOU ARE IN THE HOSPITAL _____

ARE YOU MARRIED OR SINGLE. WHO DO YOU LIVE WITH? _____

DO YOU HAVE A GOOD SUPPORT SYSTEM ? _____

HOMEMAKING RESPONSIBILITIES I DEP WHO HELPS _____

BILL PAYING I DEP WHO HELPS _____

MEDICATION MANAGEMENT I DEP WHO HELPS _____

MODE OF TRANSPORTATION _____

OCCUPATION- F/T P/T WHAT TYPE _____

IF YOU DON'T WORK ARE YOU ON DISABILITY? _____

ACL LEVEL _____

WHAT ARE SOME THINGS YOU DO FOR FUN? _____

HOW WELL DO YOU COPE WITH STRESS _____

HOW WELL DO YOU SPEAK UP FOR YOURSELF, SAY NO , AND ASK FOR WHAT YOU NEED? _____

IS THERE ANYTHING ELSE WE NEED TO WORK ON WHILE YOU ARE HERE?