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?