**PROGRESS NOTE**

**Pain Assessment and Documentation Tool (PADT™)**

Patient Name: __________________________ Record #: ________________
Assessment Date: _________________________________________________

### Current Analgesic Regimen

<table>
<thead>
<tr>
<th>Drug name</th>
<th>Strength (eg, mg)</th>
<th>Frequency</th>
<th>Maximum Total Daily Dose</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

(Continued on reverse side)

### Analgesia

If zero indicates "no pain" and ten indicates "pain as bad as it can be," on a scale of 0 to 10, what is your level of pain for the following questions?

1. What was your pain level on average during the past week? (Please circle the appropriate number)
   - **No Pain** 0 1 2 3 4 5 6 7 8 9 10 **Pain as bad as it can be**

2. What was your pain level at its worst during the past week?
   - **No Pain** 0 1 2 3 4 5 6 7 8 9 10 **Pain as bad as it can be**

3. What percentage of your pain has been relieved during the past week? (Write in a percentage between 0% and 100%).
   - ________________

4. Is the amount of pain relief you are now obtaining from your current pain reliever(s) enough to make a real difference in your life?
   - **Yes**  □  □  □  **No**  □  □  □

5. **Query to clinician**: Is the patient's pain relief clinically significant?
   - **Yes**  □  □  □  **No**  □  □  □  **Unsure**  □  □  □

### Activities of Daily Living

Please indicate whether the patient's functioning with the current pain reliever(s) is Better, the Same, or Worse since the patient's last assessment with the PADT.* (Please check the box for Better, Same, or Worse for each item below.)

<table>
<thead>
<tr>
<th></th>
<th>Better</th>
<th>Same</th>
<th>Worse</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* If the patient is receiving his or her first PADT assessment, the clinician should compare the patient's functional status with other reports from the last office visit.

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**PROGRESS NOTE**

**Pain Assessment and Documentation Tool (PADT™)**

### Adverse Events

1. Is patient experiencing any side effects from current pain reliever(s)?
   - Yes
   - No

**Ask patient** about potential side effects:

<table>
<thead>
<tr>
<th>None</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Nausea</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
</tr>
<tr>
<td>b. Vomiting</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
</tr>
<tr>
<td>c. Constipation</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
</tr>
<tr>
<td>d. Itching</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
</tr>
<tr>
<td>e. Mental cloudiness</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
</tr>
<tr>
<td>f. Sweating</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
</tr>
<tr>
<td>g. Fatigue</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
</tr>
<tr>
<td>h. Drowsiness</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
</tr>
<tr>
<td>i. Other</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
</tr>
<tr>
<td>j. Other</td>
<td>❑</td>
<td>❑</td>
<td>❑</td>
</tr>
</tbody>
</table>

2. Patient’s overall severity of side effects?
   - None
   - Mild
   - Moderate
   - Severe

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### Potential Aberrant Drug-Related Behavior

*This section must be completed by the physician.*

Please check any of the following items that you discovered during your interactions with the patient. Please note that some of these are directly observable (e.g., appears intoxicated), while others may require more active listening and/or probing. Use the “Assessment” section below to note additional details.

- Purposeful over-sedation
- Negative mood change
- Appears intoxicated
- Increasingly unkempt or impaired
- Involvement in car or other accident
- Requests frequent early renewals
- Increased dose without authorization
- Reports lost or stolen prescriptions
- Attempts to obtain prescriptions from other doctors
- Changes route of administration
- Uses pain medication in response to situational stressor
- Insists on certain medications by name
- Contact with street drug culture
- Abusing alcohol or illicit drugs
- Hoarding (i.e., stockpiling) of medication
- Arrested by police
- Victim of abuse
- Other: ________________________________

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**Assessment:** (This section must be completed by the physician.)

Is your overall impression that this patient is benefiting (e.g., benefits, such as pain relief, outweigh side effects) from opioid therapy?

- Yes
- No
- Unsure

Comments: _____________________________________________________________________________________

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**Specific Analgesic Plan:**

- Continue present regimen
  - Comments: __________________________________________________
- Adjust dose of present analgesic
- Switch analgesics
- Add/Adjust concomitant therapy
- Discontinue/taper off opioid therapy

Date: ___________________________  Physician’s signature: ________________

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