Pain Recovery Record

DISCLAIMER: This template is for educational and personal use only. It is not a substitute for professional medical advice or treatment. Always consult with your healthcare providers about your medical care.

Personal Information

Name: _____ Date of Birth: _____ Date Updated: _____

Emergency Contact: _____ Phone: _____

Primary Care Provider: _____ Phone: _____

Pharmacy: _____ Phone: _____

Current Support Team

Specialist: _____ Phone: _____

Therapist/PT: _____ Phone: _____

Other: _____ Phone: _____

Current Medications & Allergies -Medications (include dosage & frequency):

_____

_____

_____

Allergies/Reactions:

_____

_____

Primary Condition(s) Date of Diagnosis: _____

Main Diagnosis: _____

Current Symptoms: _____

Key Medical Events Timeline -(surgeries, major changes in symptoms, significant treatments)

Date Event

_____ _____

_____ _____

_____ _____

What Has Helped - Treatments/Approaches that improved symptoms:

_____

_____

_____

What Hasn't Helped - Treatments/Approaches that didn't work or caused problems:

_____

_____

_____

Daily Impact & Triggers

Activities affected: _____

What makes symptoms worse: _____

What helps reduce symptoms: _____

Notes

_____

_____

Tips for using this form:

Keep answers brief and focused

Update before appointments

Make copies for different providers

Keep both digital and paper versions