Just In Case

Complete this form and keep it where you can easily find it if you need to go to the emergency department.

Your insurance card number_____________________________________________________

The name and contact information for your regular physician
____________________________________________________________________________

Your pain diagnosis, if you have one
____________________________________________________________________________

Any other conditions you have been diagnosed with, such as diabetes or a heart condition
____________________________________________________________________________

A list of your current medications, who prescribed each, your current dosage, and how often you take them.

Be sure to include:
Prescription medications
Over the counter medications
Vitamins
Herbal supplements

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
<th>Frequency</th>
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A list of any devices or other types of intervention you now use, such as a pump, nerve block, or stimulator
____________________________________________________________________________
____________________________________________________________________________

A list of any medications that you don’t tolerate well or have had a bad reaction to in the past
____________________________________________________________________________
____________________________________________________________________________

A list of your allergies.
____________________________________________________________________________

www.theacpa.org 800.533.3231
Take this page with you to help you quickly describe your current pain problem

Location of your pain

Its intensity on a scale of ten

1 2 3 4 5 6 7 8 9 10

When this pain flare began________________________________________________________

Has anything recently aggravated your pain?
______________________________________________________________________________
______________________________________________________________________________

What helps?
______________________________________________________________________________
______________________________________________________________________________

What makes it worse?
______________________________________________________________________________

Medications that have helped your pain before
______________________________________________________________________________
______________________________________________________________________________

How it feels: (circle all that apply)
aching penetrating
nagging tingling
stabbing throbbing
burning radiating
numb gnawing
tender sharp