Chronic Pain Patient Questionnaire

Today's date: _____

Patient Name: _____ MRN/DOB: _____

Assessment

Do you have pain in the front of your body? If so, where is it located?

_____

_____

Do you have pain in the back of your body? If so, where is it located?

_____

_____

Please list any prior opioid treatments you have had. Some of these might include tramadol, hydrocodone, oxycodone, morphine, or oxymorphone (brand names include: Ultram, Vicodin, Lorcet, Percocet, MS Contin, and Opana).

_____

_____

Please list any prior NSAID treatment you have received for your pain (including over the counter medications like ibuprofen or Aleve or prescription medication).

_____

_____

Please list any additional medications prescribed specifically for nerve pain (including gabapentin, Lyrica, antidepressants, or medications used for seizures).

_____

_____

Please list any benzodiazepines you have taken in the past (including alprazolam, lorazepam, diazepam, clonazepam; brand names include Xanax, Ativan, Valium, Klonopin).

_____

_____

Please state if you have received any physical therapy for your pain.

_____

_____

How are you treating your pain other than with medications (acupuncture, chiropractic treatment, massage, biofeedback, injections or others)?

_____

_____

Pain Relief	Activities of Daily Living
Please indicate your pain on a scale of 0-10, for the following questions. (circle the appropriate number)	Please indicate how pain has interfered with your functioning in the last week on a scale of 0-10. (circle the appropriate number)
1. 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**	**1. General activity** **Does not interfere** **0 1 2 3 4 5 6 7 8 9 10** **Completely interferes**
2. What was your pain level at its *least* during the past week? **No Pain** 0 1 2 3 4 5 6 7 8 9 10 **Pain as bad as it can be**	**2. Mood** **Does not interfere** **0 1 2 3 4 5 6 7 8 9 10** **Completely interferes**
3. What was your pain level *on average* 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. Walking ability** **Does not interfere** **0 1 2 3 4 5 6 7 8 9 10** **Completely interferes**
4. What is your pain level *right now*? **No Pain** 0 1 2 3 4 5 6 7 8 9 10 **Pain as bad as it can be**	**4. Normal work** **Does not interfere** **0 1 2 3 4 5 6 7 8 9 10** **Completely interferes**
	5. Relations with other people **Does not interfere** **0 1 2 3 4 5 6 7 8 9 10** **Completely interferes**
	6. Sleep **Does not interfere** **0 1 2 3 4 5 6 7 8 9 10** **Completely interferes**
	7. Enjoyment of life **Does not interfere** **0 1 2 3 4 5 6 7 8 9 10** **Completely interferes**

Opioid Risk Tool		
Mark each box that applies to you	***Female***	***Male***
Family history of substance abuse		
Alcohol	1	3
Illegal drugs	2	3
Prescription drugs	4	4
Personal history of substance abuse	***Female***	***Male***
Alcohol	3	3

	Female	*Male*
Illegal drugs	4	4
Prescription drugs	5	5
Age between 16—45 years	1	1
History of preadolescent sexual abuse	3	0
Psychological disease		
Attention Deficit Disorder, Obsessive-Compulsive Disorder, Bipolar Disorder, Schizophrenia	2	2
Major Depression	1	1
Scoring totals		

Depression Screening

Over the last 2 weeks, how often have you been bothered by any of the following problems? Read each item carefully, and mark your response.

	Not at all	Several days	More than half the days	Nearly every day
	0	1	2	3
a. Little interest or pleasure in doing things				
b. Feeling down, depressed, or hopeless				
c. Trouble falling asleep, staying asleep, or sleeping too much				
d. Feeling tired or having little energy				
e. Poor appetite or overeating				
f. Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down				
g. Trouble concentrating on things such as reading the newspaper or watching television				
h. Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual				
i. Thinking that you would be better off dead or that you want to hurt yourself in some way				
Totals				

If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? (circle your answer)

Not Difficult at All Somewhat Difficult Very Difficult Extremely Difficult