Vitals:
BP:
P:
Temp:
Urine: Y/N

PMQ:
CCESD:

Pain Questionnaire

Patient Name:____ Date of Birth: __________________

With '0' being 'no pain' and '10' being 'the worst possible pain', please indicate your level of pain over the past 2-4 weeks in response to the following questions:

1. **How severe was your pain at its worst this past 30 days? ___ 0 to 10 scale**
2. **What was the lowest level of pain you had during the past 30 days? ___ 0 to 10 scale**
3. **How severe is your pain most of the time on your medication? ___ 0 to 10 scale**
4. **Where is your most severe pain located? Low back, middle back, neck, abdomen, head, arm, leg, other: ____**
5. **Have you seen another medical provider, been in the emergency room, or hospitalized since your last visit or within the past 30 days? Yes / No** ***If yes please inform the staff and medical provider, thank you.***
6. **Do you experience any of the following side-effects from your pain medication? (*circle all that apply*) nausea, breathing difficulty or changes, drowsiness, nervousness, sweating, constipation, itching, changes in mood, emotions or personality, difficulty with emptying bladder, sleep problems, nightmares, mental fogginess, dizziness, abdominal pain or heartburn, rash, retaining fluid or edema, other:____**
7. **Give a few examples of positive improvements in your life as a result of your medication: ____________________ ____**

Yes	No	
____	____	**I store my medications in a SAFE location such as a lock box or safe.**
____	____	**I need help for an addiction problem or drinking problem.**
____	____	**My mobility is better as a result of my medication.**
____	____	**I am able to help more with household chores such as vacuuming, taking out trash, folding laundry and preparing meals, washing dishes, etc. as a result of my medication.**
____	____	**I am able to get along better with family and friends as a result of my medications.**
____	____	**My mood and quality of life have both improved as a result of my medications.**
____	____	**I think I should continue my pain medications because of how much they have helped in my life.**
____	____	**Have you received pain medications from any other physician since your last visit?**
____	____	**I have been arrested or ticketed for any reason by law enforcement in the past 12 months.**
____	____	**I have been involved in an auto accident with the past 90 days.**
____	____	**I am actively trading and selling my medications knowingly in violation of the law.**
____	____	**I have been exaggerating my pain in order to obtain more medication than needed because I feel addicted to them.**
____	____	**My medications have been lost or stolen since my last visit.**
____	____	**I have taken more medication than I am prescribed since my last visit.**
____	____	**I have taken someone else's medication since my last visit.**
____	____	**I have used alcohol and/or illicit drugs, including marijuana, since my last visit.**
____	____	**I plan to become pregnant in the near future or may be pregnant now.**

____ ____________________ _______________
Patient Signature **Date** **Provider Initials**

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