Vitals - WEIGHT: ____
BP:
Pulse:
Pain Level:
Temp:

OKLAHOMA PAIN CENTER

Pain Questionnaire

Patient Name: **Date of Birth:** Age:

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. Since your last visit, has your pain improved, worsened, or stayed the same?

_____

2. How severe was your pain at its worst this past 30 days? ___ 0 to 10 scale
3. What was the lowest level of pain you had during the past 30 days? ___ 0 to 10 scale
4. How severe is your pain most of the time on your medication? ___ 0 to 10 scale
5. Where is your most severe pain located? Low back, middle back, neck, abdomen, head, arm, leg, other_____
6. 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. With whom?_____

_____

Were any medications started, discontinued, or adjusted?_____

7. 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_____
8. Give a few examples of positive improvements in your life as a result of your medication, for example: sleeping better, better activity, remain at work, less suffering on a daily basis, etc.

_____

_____

9. When did you take your last dose of pain medication?

_____

10. Give examples of ways you try to manage your pain besides taking pain medication. For example: Dietary changes, counseling/stress reduction, exercises, stretching, yoga, Physical Therapy, chiropractic, surgery, epidural injections, stimulator trial, burning of the nerves (RF ablation), etc.

_____

_____

PLEASE COMPLETE REVERSE SIDE

Patient Signature _____ Date _____

Provider Signature _____

S. Blake Kelly, MD*****Christopher Bradhshaw, DO
Jennifer McReynolds, PA-C Matthew Munda, APRN Meredith Pruitt, PA-C, Karie Stewart, APRN Stacy Torres, APRN, Courtney Price-PA-C
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Vitals - WEIGHT: ____
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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 illegal drugs since my last visit.
____	____	I have had alcohol in the last 30 days or since my last appointment.
____	____	I plan to become pregnant in the near future or may be pregnant now.
____	____	I have used marijuana illicitly, without a medical marijuana card.
____	____	I have reviewed my past medical and medication history and corrected anything that was not accurate. **initial _____ **
____	____	I understand that I am to be alcohol abstinent while under the treatment with opioids for chronic pain. I understand that I am not to ingest Kratom which can be bought at a store legally and is a natural opioid.
____	____	I understand under no circumstance am I to take any medication from another person.

There are other treatments for pain that we can suggest. If you are interested and haven't tried the following options, we can help you with options such as physical therapy, alternative treatments, surgical considerations, spine or joint injections, smoking cessation, weight loss, or referral to a specialist for arthritis, orthopedics, etc. If you haven't tried buprenorphine as part of your medication regimen, I highly recommend it. It has the potential to provide additional pain relief. Feel free to ask your provider for additional information. Thank you.

_____ _____

Patient Signature Date

Provider Initials _____

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