

Welcome to Advanced Pain Medicine Associates. Your appointment is scheduled for:

Date: Check-In Time:

In this packet, you will find all of the patient forms required by Advanced Pain Medicine Associates for your initial appointment. ***Please complete at home and bring with you to your appointment***.

**(*We may have to reschedule if you have not filled out these forms completely by the time of your appointment.*)**

\*\*Any missed, rescheduled or canceled appointment with less than 24-hour notice may be charged a fee\*\*

**\*\*THE FOLLOWING MUST BE BROUGHT TO YOUR APPOINTMENT\*\***

1. **Photo ID and insurance cards (MVA and/or Work Comp information if related).**
2. **Any X-Ray, MRI, or CT scan reports and films that you have.**
3. **All medication that you are currently taking for your pain (in their original bottles).**
4. **Any other information that you think is relevant.**

***\*\*IN REGARDS TO MEDICATION MANAGEMENT, THERE IS NO GUARANTEE THAT YOU WILL BE PRESCRIBED AND/OR***

***KEPT AT YOUR CURRENT DOSING; IT IS CASE BY CASE AND AT THE PROVIDER'S DISCRETION\*\****



# CONTACT INFORMATION:

**3715 N. Oliver Wichita, KS 67220**

**Phone: (316) 942-4519 opt. 4**

**Fax: (316) 942-4655**

From I-35 North/South – Exit off I-35 at **exit 53** toward KS-96/WICHITA (Turnpike Toll). Merge onto KS-96 W toward HUTCHINSON. Take the OLIVER exit. Turn RIGHT onto N OLIVER ST. Proceed ¼ mile to facility on left. Advanced Pain Medicine Associates is located at the corner of Oliver and 37th street.

From 135 South – Merge onto KS-96 E via **EXIT 10A**. Take the OLIVER exit. Turn LEFT onto N OLIVER ST. Proceed ¼ mile to facility on left. Advanced Pain Medicine Associates is located at the corner of Oliver and 37th street.

From 135 North – Merge onto KS-96 E via **EXIT 10**. Take the OLIVER exit. Turn LEFT onto N OLIVER ST. Proceed ¼ mile to facility on left. Advanced Pain Medicine Associates is located at the corner of Oliver and 37th street.

From 235 South – Merge onto I-135 S/US-81 S/KS-15 S/KS-96 E **via EXIT 16A**. **Continue .8 Miles** and Merge onto KS-96 E via **EXIT 10**. Take the OLIVER exit. Turn LEFT onto N OLIVER ST. Proceed ¼ mile to facility on left. Advanced Pain Medicine Associates is located at the corner of Oliver and 37th street.

**ADVANCED PAIN MEDICINE ASSOCIATES**

***\*\*Providing Hope for Pain Sufferers\*\****

**3715 N. Oliver, Wichita, KS 67220 Tel. 316.942.4519 Fax 316-942.4655**

**JON C. PARKS M.D. GEORGE G. FLUTER M.D.**

**NEW PATIENT EVALUATION**

 Today’s Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient’s Full Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Preferred Language:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Date of Birth:\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_ Sex:\_\_\_\_\_ Married:\_\_\_ Single:\_\_\_ Divorced:\_\_\_ Widowed:\_\_\_

 Ethnicity: Hispanic or Latino\_\_\_\_ Not Hispanic or Latino\_\_\_\_ Decline to Specify­­\_\_\_\_\_

 Race: White\_\_\_\_ African American\_\_\_\_ Asian\_\_\_\_ American Indian\_\_\_\_ Decline to Specify\_\_\_\_

 Employment Status: Currently Employed\_\_\_\_ Retired\_\_\_\_ Disabled\_\_\_\_ Unemployed\_\_\_\_

 **CURRENT MEDICATIONS:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **ALLERGIES: REACTION:**

Latex \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Iodine \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Contrast Dye \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Shellfish \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Penicillin \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Sulfa Drugs \_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PERSONAL & FAMILY MEDICAL HISTORY (check all that apply):**

 **You Family Family Relation**

Heart Attack \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Chest Pain \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Heart Murmur \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Heart Palpitations \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 High Cholesterol \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Congestive Heart Failure \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 High Blood Pressure \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Low Blood Pressure \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Blood Clots \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Heart Disease \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Asthma \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Emphysema \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ ­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Bronchitis \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Tuberculosis \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Pleurisy \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Pneumonia \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 COPD \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Long-Term Oxygen Therapy \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Sleep Apnea \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 CPAP Ventilation \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Kidney Disease \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Dialysis \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Cirrhosis \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Hepatitis \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Ulcers \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Irritable Bowel Syndrome \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 GERD \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Crohn’s Disease \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Bowel Obstruction \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Hypothyroidism \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Hyperthyroidism \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Stroke \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Epilepsy/Seizures \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Diabetes Type 1 \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Diabetes Type 2 \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **PERSONAL & FAMILY MEDICAL HISTORY (continued):**

 **You Family Family Relation**

 Cancer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Leukemia \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Scarlet Fever \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Rheumatic Fever \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Arthritis \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Rheumatoid Arthritis \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 HIV/AIDS \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Fibromyalgia \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Gout \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Lupus \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 MRSA \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Depression \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Anxiety \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Suicide/Attempts \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Alcoholism \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Illicit Drug Use \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Prescription Drug Use \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Psychiatric Treatment \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (out-patient)

 Psychiatric Treatment \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (in-patient)

 **PAST SURGICAL HISTORY:**

 **Orthopedic:**

 Hip YR/MD/TYPE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Knee YR/MD/TYPE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Joint YR/MD/TYPE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Spine:**

 Cervical YR/MD/TYPE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hardware: (Y/N)

 Thoracic YR/MD/TYPE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hardware: (Y/N)

 Lumbar YR/MD/TYPE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hardware: (Y/N)

 **Cardiovascular:**

 Valve Replacement YR/MD:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Catheterization YR/MD:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Pacemaker YR/MD:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Stent Placement YR/MD:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **PAST SURGICAL HISTORY (continued):**

 **General:**

Appendectomy YR/MD:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Gallbladder YR/MD:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Hernia YR/MD:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Upper/Lower EGD YR/MD:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Colonoscopy YR/MD:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Gastric Bypass YR/MD:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Hemorrhoidectomy YR/MD:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Lung Surgery YR/MD:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Tonsillectomy YR/MD:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Adenoidectomy YR/MD:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Thyroid YR/MD:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Kidney Surgery YR/MD:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Lithotripsy YR/MD:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Partial Colectomy YR/MD:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Exploratory Laparoscopy YR/MD:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Other Implanted Devices: YR/MD:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Head:**

Sinus YR/MD/TYPE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Eye YR/MD/TYPE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Oral YR/MD/TYPE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Nose YR/MD/TYPE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Ear YR/MD/TYPE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Reproductive:**

 Tubal Ligation YR/MD:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 C-Section YR/MD:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 D&C YR/MD:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Mastectomy YR/MD:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Hysterectomy YR/MD:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Oophorectomy YR/MD:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Vasectomy YR/MD:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Prostate YR/MD:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **SOCIAL HISTORY:**

Are you right or left-handed?\_\_\_\_\_\_\_\_\_\_\_\_ With whom do you currently reside?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Are you currently able to take care of yourself? Yes \_\_\_ No \_\_\_

 If no, please give the name and phone number of your caregiver:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Are you presently involved in a lawsuit related to your pain issue: Yes \_\_\_ No \_\_\_

 If yes, please list your attorney’s name and phone number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 If Workers’ Compensation related, please list the employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Please select your highest education level: GED \_\_\_ High School Diploma \_\_\_ Some College \_\_\_

 Associate’s Degree \_\_\_ Bachelor’s Degree \_\_\_ Master’s Degree \_\_\_ Doctorate \_\_\_

 **SUBSTANCE USE:**

 **Never Seldom Socially Monthly Weekly Daily**

Beer \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_

 Wine \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_

 Hard Liquor \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_

 Caffeine \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_

 Illicit Substances \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_

 Marijuana \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_ \_\_\_\_\_\_\_

 Do you currently smoke cigarettes or use tobacco in any form? Yes \_\_\_ No \_\_\_

 If no, have you ever in the past? Yes \_\_\_ No \_\_\_

 How many packs do/did you smoke or use per day?\_\_\_\_\_\_\_\_\_\_ How many years?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **PREVIOUS THERAPIES (check all that apply):**

Physical Therapy YR/Duration:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Improvement (y/n):\_\_\_\_\_\_

 Chiropractic Care YR/Duration:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Improvement (y/n):\_\_\_\_\_\_

 Water Therapy YR/Duration:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Improvement (y/n):\_\_\_\_\_\_

 Anti-inflammatories YR/Duration:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Improvement (y/n):\_\_\_\_\_\_

 Opioid Medications YR/Duration:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Improvement (y/n):\_\_\_\_\_\_

 Epidural Steroid Injections YR/Duration:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Improvement (y/n):\_\_\_\_\_\_

 TENS Unit YR/Duration:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Improvement (y/n):\_\_\_\_\_\_

 Lyrica/Gabapentin/Topamax YR/Duration:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Improvement (y/n):\_\_\_\_\_\_

 Muscle Relaxers YR/Duration:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Improvement (y/n):\_\_\_\_\_\_

 Heat Therapy YR/Duration:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Improvement (y/n):\_\_\_\_\_\_

 Ice Therapy YR/Duration:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Improvement (y/n):\_\_\_\_\_\_

 Acupuncture YR/Duration:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Improvement (y/n):\_\_\_\_\_\_

 Spinal Cord Stimulator YR Implanted:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Improvement (y/n):\_\_\_\_\_\_

 **PREVIOUS TESTING/STUDIES (check all that apply):**

X-ray \_\_\_ YR/Facility Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 CT \_\_\_ YR/Facility Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 MRI \_\_\_ YR/Facility Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 NCV/EMG \_\_\_ YR/Facility Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **FUNCTIONAL LIMITATIONS/PAIN HISTORY/HPI (circle all that apply):**

 **Activities avoided due to pain:**

 Work Exercise

 Physical Labor Driving

 Self-care Intimacy

 Activities of Daily Living

 **How often do you experience pain:**

 Constantly (100%)

 Frequently (75% of the time)

 Intermittently (50% of the time)

 Occasionally (25% of the time)

 **Indicate any of the following that describes your usual pain quality:**

 Burning Shooting Pressure

 Throbbing Sharp Numbness

 Dull/ache Cramping Tingling

 **Time of day your pain is worse:**

 Worse in the morning

 Worse in the evening

 Worse when trying to sleep

 No pattern

 **Indicate your usual level of pain:**

 Mild Very Severe

 Uncomfortable Unbearable

 Distressing

 **How often do you lie down during the day due to pain:**

 Never Constantly

 Seldom Often

 Sometimes

 **FUNTIONAL LIMITATIONS/PAIN HISTORY (continued:)**

 **What makes your pain worse:**

 Lying Down Bending/Twisting

 Standing Coughing/Sneezing

 Sitting Urination

 Walking Bowel Movement

 Exercise Heat

 Medications Ice

 **What makes your pain better:**

 Lying Down Bending/Twisting

 Standing Coughing/Sneezing

 Sitting Urination

 Walking Bowel Movement

 Exercise Heat

 Medications Ice

 **Does your pain stop when you quit the above activities:**

 Always

 Sometimes

 Never

 **Circle your daily level of pain you experience on average using a scale of 0 to 10. “0” being no pain**

 **and “10” being the worst pain you have ever experienced:**

*No Pain - 0 1 2 3 4 5 6 7 8 9 10 - Worst Pain*

 **REVIEW OF SYSTEMS (circle all that apply):**

 **Constitutional: Head:**

Weight Changes Headache

Fever Migraine

 Fatigue Sinus Pain

 Recent Falls Facial Pain

 Chills

 Night Sweats

 Recent Infection

 **Otolaryngeal: Pulmonary:**

Mouth Sores Shortness of Breath

 Difficulty Swallowing Difficulty Breathing

 Dentures Sleep Apnea

 Difficulty Chewing Chronic Cough

 Wheezing

 **Cardiovascular: Gastrointestinal:**

 Chest Pain Loss of Appetite

 Palpitations Recent Weight Loss

 Nausea

 Vomiting

 **Genitourinary:** Diarrhea

 Dysuria Constipation

 Hematuria Heartburn

 Genital Lesions

 Increased Urinary Frequency

 Loss of Bowel/Bladder Control

 **Hematological: Endocrine:**

 Easy Bleeding Excessive Sweating

 Easy Bruising Tendency Excessive Thirst

Change in Libido

 **Musculoskeletal: Skin:**

 Localized Joint Pain Pruritis

 Localized Joint Stiffness Skin Lesions

 Muscle Aches Rashes

 **Neurological: Psychological:**

Vertigo Sleep Disturbances

 Decreased Concentration Anxiety

 Memory Lapse or Loss Depression

 Fainting

 **PHYSICAL EXAM:**

* Using the symbols below, indicate on the diagram where you have pain.

 *XXX - Shooting/Stabbing Pain \*\*\*\*\*\*\* - Achy Pain*

 *//// - Numbness 00000 - Pins & Needles*

 *++++ - Burning Pain ##### - Other Pain*



 **NOTES:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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SOAPP® Version 1.0-14Q

Name: \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_Date: \_

***The following are some questions given to all patients at the Pain Management Center who***

***are on or being considered for opioids for their pain. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment. Thank you.***

Please answer the questions below using the following scale:

**0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 1. How often do you have mood swings? | 0 | 1 | 2 | 3 | 4 |
| 2. How often do you smoke a cigarette within an hour after |  |  |  |  |  |
| you wake up? | 0 | 1 | 2 | 3 | 4 |
| 3. How often have any of your family members, including parents |  |  |  |  |  |
| and grandparents, had a problem with alcohol or drugs? | 0 | 1 | 2 | 3 | 4 |
| 4. How often have any of your close friends had a problem with |  |  |  |  |  |
| alcohol or drugs? | 0 | 1 | 2 | 3 | 4 |
| 5. How often have others suggested that you have a drug or |  |  |  |  |  |
| alcohol problem? | 0 | 1 | 2 | 3 | 4 |
| 6. How often have you attended an AA or NA meeting? | 0 | 1 | 2 | 3 | 4 |
| 7. How often have you taken medication other than the way that it was prescribed? | 0 | 1 | 2 | 3 | 4 |
| 8. How often have you been treated for an alcohol or drug problem? | 0 | 1 | 2 | 3 | 4 |
| 9. How often have your medications been lost or stolen? | 0 | 1 | 2 | 3 | 4 |
| 10. How often have others expressed concern over your medication use? | 0 | 1 | 2 | 3 | 4 |

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**0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 11. How often have you felt a craving for medication? | 0 | 1 | 2 | 3 | 4 |
| 12. How often have you been asked to give a urine screen for substance abuse? | 0 | 1 | 2 | 3 | 4 |
| 13. How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years? | 0 | 1 | 2 | 3 | 4 |
| 14. How often, in your lifetime, have you had legal problems or been arrested? | 0 | 1 | 2 | 3 | 4 |

*Please include any additional information you wish about the above answers. Thank you.*

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