HIGHLAND FAMILY PRACTICE
4460 South Highland Dr., Suite 400
Salt Lake City, Utah 84124
801-272-4111

Controlled Pain Medication Questionnaire for:

NAME:_____ **Date Of Birth:** _____

Please circle your answer to each question as honestly as possible.
This information is for our records only and will be kept confidential.
Your answers will help us to determine your appropriate treatment.

For the last 30 days, list how often the following items apply to you.

1.	Have your grandparents, parents, brothers or sisters had a problem with alcohol or drugs?	Never	Seldom	Sometimes	Often	Very Often
2.	Has your significant other or your close friends had drug or alcohol problems?	Never	Seldom	Sometimes	Often	Very Often
3.	Have others suggested you have a problem with alcohol or drugs?	Never	Seldom	Sometimes	Often	Very Often
4.	Have you taken your medication other than the way it was prescribed?	Never	Seldom	Sometimes	Often	Very Often
5.	Have your medications been lost or stolen?	Never	Seldom	Sometimes	Often	Very Often
6.	Have others expressed concern over your use of medication?	Never	Seldom	Sometimes	Often	Very Often
7.	Have you felt cravings for your medications?	Never	Seldom	Sometimes	Often	Very Often
8.	Have you used illegal drugs? (marijuana, cocaine, speed, meth, heroin, etc.)	Never	Seldom	Sometimes	Often	Very Often
9.	Have you gotten pain medication from another doctor, clinic, friends, or street sources?	Never	Seldom	Sometimes	Often	Very Often
10.	Have you shared, traded or sold your medication?	Never	Seldom	Sometimes	Often	Very Often
11.	Have you used your pain medicine for symptoms other than pain? (improve your mood, relieve stress)	Never	Seldom	Sometimes	Often	Very Often
12.	Have you gone to the ER for pain?	Never	Seldom	Sometimes	Often	Very Often
13.	Do you use anything to prevent constipation from your medication? (Exercise, Fiber, Laxatives, Prunes or Stool Softeners)	Never	Seldom	Sometimes	Often	Very Often

Pain Level Assessment Key: (Please answer for the last 7 days)
0 = None 2 = Minor 4 = Tolerable 6 = Moderate 8 = Unbearable 10 = Extreme

Your WORST pain level?	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Your LOWEST pain level?	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Your AVERAGE pain level?	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
How much has your pain interfered with your level of activity within the last week?	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

For the last 7 days, what percentage of relief have your pain medications provided?	**0%**	**10%**	**20%**	**30%**	**40%**	**50%**	**60%**	**70%**	**80%**	**90%**	**100%**

Signature:_____ **Date:**_____ Witness:_____ **Date:**_____