

# Pain Medication Questionnaire

Boulder Pain Institute, P.C.

Name: \_\_\_\_\_ Date: \_\_\_\_\_

The following are some questions given to all patients at Boulder Pain Institute who are currently 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.

0=never, 1=seldom, 2=sometimes, 3=often, 4=very often

1. How often do you feel that your pain is “out of control?” 0 1 2 3 4
2. How often do you have mood swings? 0 1 2 3 4
3. How often do you do things that you later regret? 0 1 2 3 4
4. How often has your family been supportive and encouraging? 0 1 2 3 4
5. How often have others told you that you have a bad temper? 0 1 2 3 4
6. How often have you felt a need for higher doses of medication? 0 1 2 3 4
7. How often do you take higher doses than prescribed? 0 1 2 3 4
8. How often have any relatives had a problem with drugs/alcohol? 0 1 2 3 4
9. Do your close friends have a problem with drugs/alcohol? 0 1 2 3 4
10. Do others suggest you have a problem with drugs/alcohol? 0 1 2 3 4
11. Do you attend AA or NA? 0 1 2 3 4
12. Do you see a psychiatrist or mental health provider? 0 1 2 3 4
13. Have you been treated for drug/alcohol problems? 0 1 2 3 4
14. How often have your medications been lost or stolen? 0 1 2 3 4
15. Do you or have you used illicit drugs? 0 1 2 3 4
16. Have you been arrested? 0 1 2 3 4
17. Two or more providers have simultaneously prescribed meds? 0 1 2 3 4