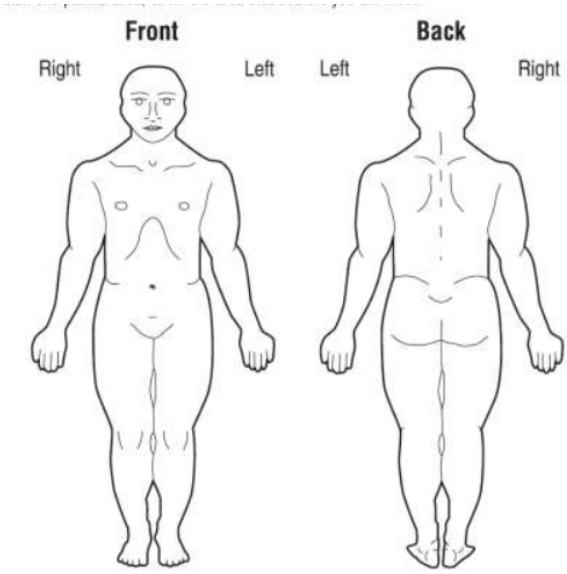
**Patient Name:**_____ **Date of Birth:**_____ **Date:**_____

1. What type of pain do you have?

_____

2. Circle the location of your pain:




3. Does the pain radiate (move) to any other location of your body?
**NO YES** If yes, where: _____

4. Describe the type of pain (Circle ALL that apply)
**SHARP STABBING DULL ACHY**
**BURNING CRUSHING THROBBING**
**SHOOTING TWISTING STRETCHING**

5. When did the pain start?

_____

6. Is the pain constant? **YES NO** If no, indicate the frequency *(e.g. times per day or per week)*

_____

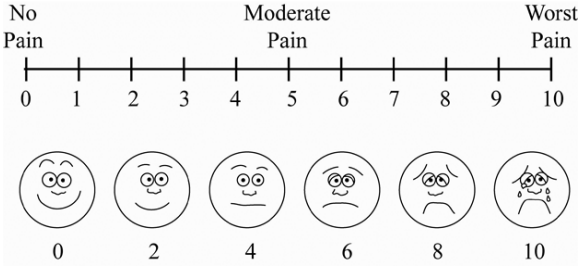
7. Circle things that make the pain better (Circle ALL that apply)
**HEAT ICE PHYSICAL THERAPY**
**MASSAGE REST POSITION CHANGES**
**MEDICATION Other:** _____

8. Does anything make the pain worse? **NO YES**
If yes, describe: _____

9. Please list any additional symptoms you have with the pain: _____

_____

10. Please circle the severity of the pain on the scale below:




11. Does your pain interfere with any of the following: (Circle ALL that apply)
**WALKING MOOD SLEEP**
**SEX LIFE WORK TOILETING**
**BATHING DRESSING EATING**
**PREPARING MEALS HOUSEWORK**
**RELATIONSHIPS GETTING OUT OF BED**

12. List current pain medications (including prescription, over-the-counter medications and supplements)

_____

_____

13. Current medication side effects? **NO YES**
If yes, describe: _____

14. List other pain medications previously tried (including prescription, over-the-counter medications and supplements)

_____

_____

15. Goals of treatment

_____

_____

*Provider signature:*_____ *Date reviewed:*_____

Patient Name: _____ Date of Birth: _____ Date: _____

# Opioid Risk Tool (ORT)

| | | **Mark each box that applies** |
|---|---|---|
| Family History of Substance Abuse | Alcohol | ☐ |
| | Illegal Drugs | ☐ |
| | Prescription Drugs | ☐ |
| Personal History of Substance Abuse | Alcohol | ☐ |
| | Illegal Drugs | ☐ |
| | Prescription Drugs | ☐ |
| Age (mark box if 16-45) | | ☐ |
| History of Preadolescent Sexual Abuse | | ☐ |
| Psychological Disease | Attention Deficit Disorder | ☐ |
| | Obsessive Compulsive Disorder | ☐ |
| | Bipolar | ☐ |
| | Schizophrenia | ☐ |
| | Depression | ☐ |

Total ☐

Reference: Webster LR. Predicting aberrant behaviors in opioid-treated patients: Preliminary validation of the opioid risk tool. *Pain Medicine*. 2005; 6(6):432-442.

Patient Name: _____ Date of Birth: _____ Date: _____

# STOP-BANG Sleep Apnea Questionnaire

*Chung F et al Anesthesiology 2008 and BJA 2012*

| **STOP** | | |
|---|---|---|
| Do you **S**NORE loudly (louder than talking or loud enough to be heard through closed doors? | Yes | No |
| Do you often feel **T**IRED, fatigued or sleepy during the daytime? | Yes | No |
| Has anyone **O**BSERVED you stop breathing during your sleep? | Yes | No |
| Do you have or are you being treated for high blood **P**RESSURE? | Yes | No |

| **BANG** | | |
|---|---|---|
| **B**MI more than 35 kg/m2? | Yes | No |
| **A**GE over 50 years old? | Yes | No |
| **N**ECK circumference >16 inches (40cm)? | Yes | No |
| **G**ENDER: Male? | Yes | No |

| **TOTAL SCORE** | | |
|---|---|---|

**High Risk of OSA: Yes 5-8**

**Intermediate Risk of OSA: Yes 3-4**

**Low Risk of OSA: Yes 0-2**

Patient Name: _____ Date of Birth: _____ Date: _____

# Patient Health Questionnaire (PHQ-9)

**Over the last 2 weeks how often have you been bothered by any of the following problems? (Please circle the number to indicate your answer for each item)**

| | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|
| 1) Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| 2) Feeling down, depressed or hopeless | 0 | 1 | 2 | 3 |
| 3) Trouble falling or staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| 4) Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| 5) Poor appetite or overeating | 0 | 1 | 2 | 3 |
| 6) Feeling bad about yourself or that you are a failure or have let yourself or your family down | 0 | 1 | 2 | 3 |
| 7) Trouble concentrating on things such as reading the newspaper or watching television | 0 | 1 | 2 | 3 |
| 8) Moving or speaking so slowly that other people could have noticed. Or the opposite-being so fidgety or restless that you have been moving around a lot more than usual | 0 | 1 | 2 | 3 |
| 9) Thoughts that you would be better off dead, or hurting yourself in some way | 0 | 1 | 2 | 3 |

**TOTAL SCORE:** 

Patient Name: _____ Date of Birth: _____ Date: _____

STABLE RESOURCE TOOLKIT

## CAGE – AID Questionnaire

Patient Name: _____

Date of Visit: _____

When thinking about drug use, include illegal drug use and the use of prescription drug use other than prescribed.

| Questions: | Yes | No |
|---|---|---|
| 1.) Have you ever felt that you ought to cut down on your drinking or drug use? | | |
| 2.) Have people annoyed you by criticizing your drinking or drug use? | | |
| 3.) Have you ever felt bad or guilty about your drinking or drug use? | | |
| 4.) Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? | | |

Patient Name: _____ Date of Birth: _____ Date: _____

## Controlled Substance Agreement and Informed Consent Form

The following agreement relates to my use of controlled substances including but not limited to "narcotics/opioids," to treat chronic pain. I will be provided with prescriptions only if I understand and agree to the following:

1. I understand that, depending on the drug and dose, I can become physically dependent on the medication and can develop withdrawal symptoms if the medication is stopped suddenly or the dose reduced rapidly. Although the risk is small, there is a chance of developing an addiction to controlled substances if placed on them to help control pain. Addiction is the loss of control over the substance and/or the use of a substance in spite of the harm that it causes. If you are concerned of such loss of control, tell your provider.

2. Controlled substances can cause sedation, confusion, or other changes in mental state and thinking abilities. If this occurs, we advise that you do not drive while taking controlled substances and understand that the decision to drive while taking controlled substances is your own decision. I agree to not be involved in any activity that may be dangerous to me or someone else if I am in any way sedated, feel drowsy or am not thinking clearly. Examples of these activities include: driving, operating dangerous equipment, working in unprotected heights or being responsible for another individual who is unable to care for themselves. In the event that I am involved in a motor vehicle accident, I agree to undergo a safe driving assessment and I understand that I will be responsible for the cost of this test.

3. I will not use any other controlled substances including, but not limited to, marijuana and cocaine. I will not use alcohol while I am taking controlled substances. I will not use any other opiates not prescribed to me that I may have left-over, or from a friend, or otherwise acquired. I agree to submit a urine specimen or blood test at any time that my provider requests it and give my permission for it to be tested for alcohol and drugs.

4. I agree to come to the office with my medication the same day that I am called and submit to a pill count, and/or urine or blood screening to detect illegal substances or confirm proper use of prescribed medication. The call to come to the office can be made either randomly, or if a concern arises. I may be required to bring my unused medication routinely to each office visit. If I do not have insurance or my insurance denies testing, I understand that I will be responsible for the cost of the test.

5. The office policy regarding the dispensing of controlled substances requires that I be seen regularly, at a minimum of every 3 months, for the monitoring of my condition and review of the continued requirement for pain control medication. I agree to make and keep my appointments. Failure to do so may result in discontinuation of this treatment. I will advise my provider of all other medicines and treatments that I am receiving.

_____ _____
Initials Date

6. If the medication requires adjustment, an appointment needs to be made to see the provider. Adjustments will NOT be made over the telephone except under very unusual circumstances. I must stay with the prescribed dosing so that I do not run out of medication early. The medication is expected to last until the NEXT REFILL DUE date that is found at the bottom of the opioid prescription. I understand that the office policy is not to prescribe early. I agree that I will use my medication exactly as prescribed and that if I run out early, I may go without medication until the next prescription is due, possibly resulting in withdrawal symptoms.

7. I understand that running out of medication early, needing early refills, escalating doses of medication without permission and losing prescriptions may be signs of misuse of the medication and may be reasons for discontinuation of treatment.

8. I understand that prescriptions given to me are my responsibility once they are placed in my hand and that if anything happens to my prescription (lost, stolen, or accidentally destroyed), I may not receive a replacement from my physician. The office expects me to file a police report if my medication is stolen. I will be prepared to bring in a copy at my next office visit.

9. I agree to request pain medication refills ONLY during normal office hours and with a minimum of 48 business hours advanced notice. Requests for refills after-hours and on weekends will not be honored.

10. My provider will prescribe medication to me that has the greatest chance of improving pain control and function. This decision is thoughtful and done with your consent. My provider is not under any obligation to prescribe any specific medication.

.

11. There may be non-medicine treatments for your pain that your provider may recommend. I agree to participate in other chronic pain treatment modalities recommended. These could include physical therapy, exercise programs, injections, visits to specialists, etc.

12. I give permission for the office staff to call any pharmacy, another healthcare provider and review the CPMRS database at any time, without my being informed, to review and discuss my past or present use of controlled or illegal substances.

13. I will not use my pain medication in higher than prescribed amounts for new problems that arise (toothache, surgery, etc.) unless authorized to do so. I will inform my other providers of my use of medication for chronic pain, and I will inform the Middlesex Hospital Primary Care (MHPC) staff if another provider prescribes controlled substances for any acute problem. My provider at MHPC is my primary provider with regard to my pain medications. If there is a medical emergency (e.g. broken leg, surgery requiring post-op pain medication, dental procedures, etc.), another provider may prescribe pain medication to me, but I will advise the prescribing provider of my care at MHPC,

_____ _____
Initials Date

authorize that provider to disclose information to MHPC, and I will notify my provider at MHPC of the medication and dosage.

14. (Females only) Because of the risks of certain medications to unborn children, I will inform all providers, obstetrician/gynecologist and MHPC immediately if I become pregnant or decide to try to become pregnant. It is important to discuss your plans for pregnancy with your provider to map out a medication strategy during your pregnancy. I am aware that should I carry a baby to delivery while taking opiate medicines, the baby will be physically dependent upon opioids and will probably suffer withdrawal symptoms.

15. (Males only) I am aware that chronic opioid use has been associated with low testosterone levels in males. This may affect my mood, stamina, sexual desire and physical and sexual performance. I understand that my doctor may check my blood to see if my testosterone level is normal.

16. My provider can wean me off of controlled substances at any time if he/she feels that it is in my best interest. The weaning process can result in withdrawal symptoms. If I am weaned off, the office staff may inform my other healthcare providers as to the reasons for the weaning.

17. Abstinence Syndrome (Withdrawal Syndrome): Stopping my medication abruptly may result in withdrawal symptoms. I should wean from my medications rather than stopping them abruptly.

18. I understand that in general I may be weaned off of my medication or my drug therapy may be terminated at the discretion of my provider if any of the following occur:

    a) It is the opinion of my provider that controlled substances are not very effective for my pain and/or my functional activity is not improved.

    b) I misuse the medication.

    c) I develop rapid tolerance or loss of effect from this treatment.

    d) I develop side effects that are significant and detrimental to me.

    e) I obtain controlled substances from sources other than my MHPC provider without informing them.

    f) PIll counts or test results indicate the improper use of the prescribed medication or the use of other drugs, and /or I fail to submit to such counts/tests on the day that I am called.

_____ _____
Initials Date

g) I am arrested and/or convicted for a controlled or illicit drug violation including drunk driving.

h) Any violation of this agreement.

i) If I give away, sell, distribute and/or transport with the intent to sell or dispense my medication.

j) I alter the written prescription in any way.

19. I choose to use _____ Pharmacy, located at _____, for all of my pain medication prescriptions. I agree to not fill partial prescriptions. If my pharmacy does not stock the full quantity of medication, I will notify MHPC and fill my prescription elsewhere when possible. If I change my pharmacy for any reason, I agree to notify the office.

**I have read this Agreement, understand it, and have had all my questions concerning this Agreement answered to my satisfaction. I agree to abide by the terms of this Agreement if I am placed on controlled substances (including, but not limited to narcotic analgesics). I have received a copy of the Agreement. By signing this form voluntarily, I give my consent for the treatment of my pain with opioid and non-opioid pain medicines. If I violate the Agreement, I know that my provider may discontinue this form of treatment and that, in some circumstances, I may be dismissed from the Middlesex Hospital Primary Care Practice**

.

_____ _____

Patient Signature Date

_____

Patient Printed Name

_____ _____

Provider Signature Date

_____ _____

Initials Date