Mille Lacs Health System

Pain Inventory

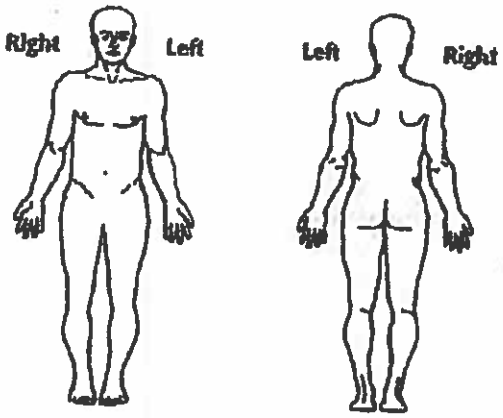
Name: _____ DOB _____

Date ____/____/____ Time: _____

1) Through our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain today?

   1. Yes 2. No

2) On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.



3) Please rate your pain by circling the one number that best describes your pain at its WORST in the last 24 hours

   1 2 3 4 5 6 7 8 9 10

4) Please rate your pain by circling the one Number that best describes your pain at its LEAST in the last 24 hours

   1 2 3 4 5 6 7 8 9 10

5) Please rate your pain by circling the one Number that best describes your pain on the AVERAGE

   1 2 3 4 5 6 7 8 9 10

6) Please rate your pain by circling the one Number that tells how much pain you have RIGHT NOW

   1 2 3 4 5 6 7 8 9 10

7) What treatments or medication are you receiving for your pain?

   _____

   _____

8) In the last 24 hours, how much relief have pain treatments or medications provided? Please circle the one percentage that shows how much RELIEF you have received.

   0% 1 2 3 4 5 6 7 8 9 10

9) Circle the one number that describes how, during the past 24 hours, pain has interfered with your:

   A. General Activity

   0% 10 20 30 40 50 60 70 80 90 100%
   Does not Interfere — Completeley Interferes

   B. Mood

   0 1 2 3 4 5 6 7 8 9 10
   Does not Interfere — completely interferes

   C. Walking Ability

   0 1 2 3 4 5 6 7 8 9 10
   Does not Interfere — completely interferes

   D. Normal work (includes both work outside the home and house work)

   0 1 2 3 4 5 6 7 8 9 10
   Does not Interfere — completely interferes

   E. Relations with other people

   0 1 2 3 4 5 6 7 8 9 10
   Does not Interfere — completely interferes

   F. Sleep

   0 1 2 3 4 5 6 7 8 9 10
   Does not Interfere — completely interferes

   G. Enjoyment of life

   0 1 2 3 4 5 6 7 8 9 10
   Does not Interfere — completely interferes

(Patient)

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In addition to completing the Pain Inventory, to help your doctor better manage your pain, please tell us:

What does the pain feel like? Circle those words that describe your pain.

Aching	throbbing	shooting
Stabbing	gnawing	pricking
Sharp	tender	burning
Exhausting	tiring	penetrating
Nagging	numb	miserable
Unbearable	dull	radiating
Squeezing	cramping	deep

How long have you had this pain?(Circle one)

Less that a week 1 to 2 weeks

2 to 4 weeks more than a month

What kinds of things make your pain feel better (for example, heat, medicine, rest)?

_____

_____

_____

What kinds of things make your pain worse (for example, walking, standing, lifting)?

_____

_____

_____

_____

Do you have any other symptoms? Circle any that apply:

Nausea	vomiting
Constipation	diarrhea
Lack of appetite	indigestion
Difficulty sleeping	feeling drowsy
Nightmares	dizziness
Tiredness	itching
Urinary problems	sweating
Weakness	headaches

Comments: Write down any question or information you need to share with your doctor, nurse, or pharmacist about your pain

_____

_____

_____

_____

_____

_____

_____

_____

_____

(Patient)

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Name: _____ DOB: _____

Date: ____/ ____/ _____ MR #: _____

Appendix C – Physical Functional Ability Questionnaire (FAQ5)

This tool has not been validated for research; however, work group
Consensus was to include it as an example due to lack of other validated
And easy-to-use functional assessment tools for chronic pain.

Instructions: Circle the number (1-4) in each of the groups that best summarizes your ability. Numbers and multiply by 5 for total score out of 100.

_____ **Self-care ability assessment**
1. Require total care: For bathing, toilet, dressing, moving and eating
2. Require frequent assistance
3. Require occasional assistance
4. Independent with self-care

_____ **Family and social ability assessment**
1. Unable to perform any: chores, hobbies, driving, sex and social activities
2. Able to perform some
3. Able to perform many
4. Able to perform all

_____ **Movement ability assessment**
1. Able to get up and walk with assistance, unable to climb stairs
2. Able to get up and walk independently, able to climb one flight of stairs
3. Able to walk short distances and climb more than one flight of stairs
4. Able to walk long distances and climb stairs without difficulty

_____ **Lifting ability assessment**
1. Able to lift up to 10 lbs. occasionally
2. Able to lift up to 20 lbs. occasionally
3. Able to lift up to 50 lbs. occasionally
4. Able to lift over 50 lbs. occasionally

_____ **Work ability assessment**
1. Unable to do any work
2. Able to work part-time and with physical limitations
3. Able to work part-time or with physical limitations
4. Able to perform normal work

_____ **Physical Functional Ability (FAQ5) Score**

(Patient)

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ **DATE:** _____

Over the *last 2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	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 of hurting yourself in some way	0	1	2	3
add columns:		+	+	
(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card.)	**TOTAL:**			

10. If you checked off *any* problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	**Not difficult at all** _____ **Somewhat difficult** _____ **Very difficult** _____ **Extremely difficult** _____

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Opioid Risk Tool (ORT)
Patient Form

Name: _____ DOB: _____

Date: _____/_____/_____ MR #: _____

Mark each box that applies		Female	Male
1. Family history of substance abuse	• Alcohol • Illegal drugs • Prescription drugs	[ ] [ ] [ ]	[ ] [ ] [ ]
2. Personal history substance abuse	• Alcohol • Illegal drugs • Prescription drugs	[ ] [ ] [ ]	[ ] [ ] [ ]
3. Age (mark box if 16-45 years)		[ ]	[ ]
4. History of preadolescent sexual abuse		[ ]	[ ]
5. Psychological disease	• Attention-deficit/hyperactivity disorder, obsessive-compulsive disorder, dipolar disorder, schizophrenia • Depression	[ ] [ ]	[ ] [ ]

(Patient)

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SOAPP-R Questionnaire

Name: _____ DOB: _____

The following are some questions give to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There is no right or wrong answers.	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
1. How often do you have mood swings?	o	o	o	o	o
2. How often have you felt a need for higher doses of medication to treat your pain?	o	o	o	o	o
3. How often have you felt impatient with your doctors?	o	o	o	o	o
4. How often have you felt that things are just too overwhelming that you can't handle them?	o	o	o	o	o
5. How often is there tension in the home?	o	o	o	o	o
6. How often have you counted pain pill to see how many are remaining?	o	o	o	o	o
7. How often have you been concerned that people will judge you for taking pain medication?	o	o	o	o	o
8. How often do you feel bored?	o	o	o	o	o
9. How often have you taken more pain medication than you were supposed to?	o	o	o	o	o
10. How often have you worried about being left alone?	o	o	o	o	o
11. How often have you felt a craving for medication?	o	o	o	o	o
12. How often have others expressed concern over your use of medication?	o	o	o	o	o
13. How often have any of your close friends had a problem with alcohol or drugs?	o	o	o	o	o
14. How often have others told you that you had a bad temper?	o	o	o	o	o
15. How often have you felt consumed by the need to get pain medication?	o	o	o	o	o
16. How often have you run out of pain medication early?	o	o	o	o	o
17. How often have others kept you from getting what you deserve?	o	o	o	o	o
18. How often, in your lifetime, have you had legal problems or been arrested?	o	o	o	o	o
19. How often have you attended AA or NA meetings?	o	o	o	o	o

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SOAPP-R Questionnaire

Name: _____ DOB: _____

The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There is no right or wrong answers.	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
20. How often have you been in a argument that was so out of control that someone got hurt?	o	o	o	o	o
21. How often have you been sexually abused?	o	o	o	o	o
22. How often have others suggested that you have a drug or alcohol problem?	o	o	o	o	o
23. How often have you had to borrow pain medications from your family or friends?	o	o	o	o	o
24. How often have you been treated for an alcohol or drug problem?	o	o	o	o	o

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____
Somewhat difficult _____
Very difficult _____
Extremely difficult _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Intern Med.* 2006;166:1092-1097.