Tucson Pain Institute

New Patient Packet

1951 W. 25TH ST SUITE #B YUMA, AZ 85364

PH. 928- 276- 3049 · FAX. 928- 259- 7006 · WWW-TPIAZ.COM

Date:

Welcome to Tucson Pain Institute (TPI). You have been referred to our facility for pain management treatment and we are happy to have you join our clinic and look forward to managing your pain.

We have made an appointment for (name) _____ on (date) _____ / _____ / _____ at (time) _____ : _____ . Please arrive 30 minutes earlier than your scheduled time.

This new patient packet must be filled out for your first appointment. Please make sure each form is filled out appropriately. If it is not filled out, your appointment may be cancelled and/ or rescheduled.

Please follow these steps to make your appointment run smoothly:

1.) Complete the Medical History Form and bring it with you to the appointment.
2.) Please bring the following to your appointment:
- Driver's License or Valid Photo ID
- Current Health Insurance Card(s)
- List of current medications that include the pill strength and dosage information

Please be advised that we require 24 hours notice for any rescheduling or cancellations this is to avoid incurring a $25 fee. This fee applies to "No Shows" as well.

Medical History (List medications you currently take):

Medication Name:	Dose:	Frequency:

Tucson Pain Institute

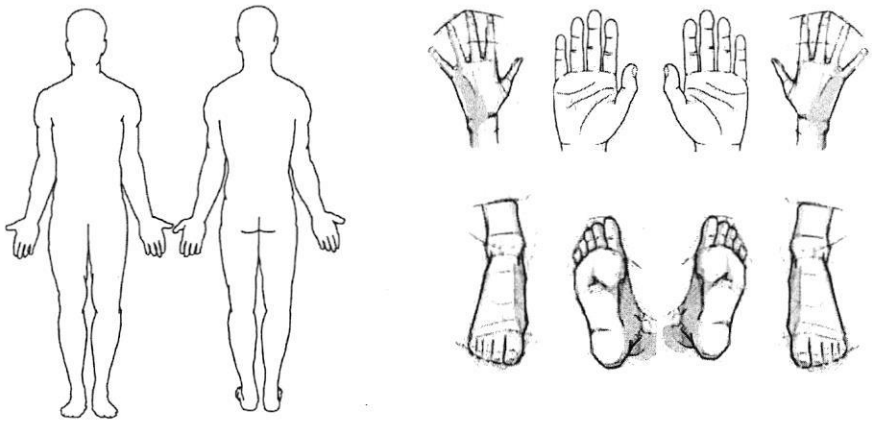
New Patient Intake Form

1951 W. 25TH ST SUITE #B ; Yuma, AZ 85364
PH. 928- 276- 3049 · FAX. 928- 259- 7006 · WWW-TPIAZ.COM

Today's Date: _____ / _____ / _____ Patient Name: _____ Height: _____ Weight: _____

Primary Care Doctor: _____ What is the reason for your visit today? _____

Explain where your pain is located (please shade in the area where you feel pain):



Is your pain (please check all that apply):

◯ Constant ◯ Intermittent

◯ Dull ◯ Sharp ◯ Shooting ◯ Aching ◯ Numbness ◯ Tingling ◯ Burning

Does your pain radiate to any other part of your body? If yes, where to?

_____

What helps to relieve your pain?

_____

What causes your pain to be worse?

_____

WITHOUT medication, on a scale from 1-10, what is your pain level? _____ **WITH medication?** _____

What daily tasks/functions are you able to do, with minimal limitations, when taking your medication that you are unable to do without them (i.e. walking, running, making breakfast, grocery shopping, bend over to tie shoes)?

_____

_____

In terms of pain relief, on scale of 0%-100%, how much pain relief do you get from taking your medication? _____ %

Past Medical History (Please check all that apply):

- ◯ Seizure Disorder
- ◯ Rheumatoid Arthritis
- ◯ Migraines
- ◯ Fibromyalgia
- ◯ Stroke
- ◯ Cancer
  Type: _____
  Diagnosis Year:_____
  Remission? Y / N
- ◯ Osteoarthrosis
- ◯ Heart Attack
- ◯ Pacemaker
- ◯ High Blood Pressure
- ◯ Atrial Fibrillation
- ◯ Blood Clots
- ◯ Diabetes: Type I or II
- ◯ Thyroid Disease
- ◯ HIV
- ◯ Lupus
- ◯ Kidney Disease
  Currently in Dialysis? Y / N
- ◯ Other
  _____

Past Surgical History:

Date of Surgery:	Procedure:	Surgeon:

Previous Treatment History:

Physical Therapy? Y / N Facility Name: _____ Date of Last Treatment: ____ / ____ / ____

Epidural Steroid Injections? Y / N Physician Name: _____ Date of Last Injection: ____ / ____ / ____

Trigger Point Injections? Y / N Physician Name: _____ Date of Last Session: ____ / ____ / ____

Chiropractic/Acupuncture? Y / N Physician Name: _____ Date of Last Session: ____ / ____ / ____

What medications have you taken in the past for your pain?

Medication Name:	Was this medication effective for pain relief? Why or why not?

Allergies:

Allergy:	Reaction Symptoms:

Family Medical History:

(What medical conditions run in your family? Please be as specific as possible)

Father:	
Mother:	
Mother:	
Mother:	

Social History:

Occupation:

_____

Marital Status:

◯ Single ◯ Married ◯ Divorced ◯ Separated ◯ Domestic Partner ◯ Widowed

Tobacco Use: Y / N Type of Tobacco: _____ Frequency: _____

Alcohol Use: Y / N Type of Alcohol: _____ Frequency: _____

Caffeine Use: Y / N Type of Caffeine: _____ Frequency: _____

Recreational Drug Use: Y / N Type of Drug(s): _____ Frequency: _____

Review of Symptoms:

◯ Fatigue ◯ Change in Appetite ◯ Sleeping Problems ◯ Fever

◯ Chills ◯ Malaise ◯ Body Aches ◯ Night Sweats

◯ Weight Loss ◯ Weight Gain ◯ Loss of Appetite

◯ Back Pain ◯ Neck Pain ◯ Joint Pain

◯ Joint Swelling ◯ Leg Cramps ◯ Muscle Cramps

◯ Muscle Pain ◯ Shoulder(s) Pain ◯ Hip(s) Pain

◯ Leg(s) Pain ◯ Wrist Pain ◯ Knee Pain

◯ Ankle Pain ◯ Elbow Pain ◯ Limitation of Motion

◯ Congenital Muscular Disease ◯ Muscle Weakness

Additional Information:

(Please feel free to use the space below if there is any additional information you would like to inform the doctor about)

_____

_____

Patient Signature: _____ Date: _____ / _____ / _____

Physician Signature: _____ Date: _____ / _____ / _____

Tucson Pain Institute
6252 E. Grant Rd. Suite 150
Tucson, Arizona 85712
Ph. 520.886-PAIN (7246)

We are committed to doing all we can to treat your chronic pain condition. In some cases, opioids and other controlled substances are used as a therapeutic option in the management of chronic pain and related conditions all of which are strictly regulated by both state and federal agencies. This agreement is a tool to protect both you and the provider (provider may be a: physician's assistant) by establishing guidelines, within the last, for proper controlled substance use. I am receiving Chronic Narcotic Administration (CNA) to treat the following medical condition(s):

I understand that there are some risks associated with CNA such as dependence, addiction, change in personality, sleep changes, bowel changes (such as constipation and even bowel obstruction), bladder changes, changes in appetite with possible weight gain or loss, coordination (which may interfere with driving and with fine motor movement), sexual desire and performance, and other. Sudden stopping of CNA can lead to rebound pain and withdrawal symptoms. I have been informed not to stop CNA suddenly unless decided jointly by myself and by you, my physician.

1. All controlled substances have a potential for dependency and abuse.
2. All controlled substances must come from the provider whose signature appears below or during his/her absence, by the covering provider, unless specific authorization is obtained for an exception. This does include ER/Urgent Care visits.
3. All controlled substances must be obtained at the same pharmacy. Should the need arise to change pharmacies, our office must be informed. The pharmacy that you have selected is: _____Phone: _____
4. The prescribing provider has permission to discuss all diagnostic and treatment details with the dispensing pharmacists or other professionals who provide your health care for purpose of maintaining accountability.
5. You may not share, sell, or otherwise permit other including spouse or family members to have access to these medications.
6. Unannounced urine or serum toxicology screens may be requested and your cooperation is required. Presence of unauthorized substances may result in your discharge from our facility. Refusal of the test will result in your discharge from our care. Absence of substances that should be in your system may also result in discharge from our facility.
7. I will not consume excessive amounts of alcohol in conjunction with narcotics, nor will I use, purchase, or otherwise obtain any illegal substances.
8. Medications may not be replaced if they are lost, stolen, get wet, are destroyed, or get left intentionally or unintentionally elsewhere (i.e. airplane, bus, different city/state). If your medication has been stolen it will not be replaced unless explicit proof is provided with direct evidence from authorities.
9. If the responsible legal authorities have questions concerning your treatment, as might occur, for example if you were obtaining medications at several pharmacies, all confidentiality is waived and these authorities may be given full access to our records of controlled substance administration.
10. Early refills will not be given. We require 3 days notice for refill requests. Refills are based upon keeping scheduled appointments. Refills will not be granted after hours or on weekends. Our hours are Monday-Friday 8:00 am-4:30 pm.
11. In the event you are arrested or incarcerated related to legal or illegal drugs, refills on controlled substances will not be given.
12. It is understood that failure to adhere to these policies may result in cessation of therapy with controlled substance prescribing by the provider.
13. Smoking increases multiple health risks including chronic pain. You will make every effort to refrain from smoking.

You affirm that you have full right and power to sign and be bound by this agreement and that you have read, understand, and accept all of its terms.

Patient Signature _____ Date _____ Provider Signature _____ Date _____

Patient Information:

Patient: _____ D.O.B. _____
Last First MI

◯ Male ◯ Female Social Security Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Work: _____

Employer: _____ Occupation: _____

Primary Insurance Coverage:

◯ Private Pay ◯ Insurance Company _____

Phone: _____ Fax: _____

Address: _____

City: _____ State: _____ Zip: _____

Insured: _____ DOB: _____ Policy #: _____ Group: _____

Relationship to Patient: _____ Person Responsible Employed By: _____

Worker's Compensation Only:

Employer: _____

Adjuster's Name/Adjuster's Phone #, Date of Injury

Diagnosis: _____

Secondary Coverage:

Insurance Company: _____

Phone: _____ Fax: _____

Address: _____

City: _____ State: _____ Zip: _____

I HEREBY AUTHORIZE TUCSON PAIN INSTITUTE TO RELEASE ANY INFORMATION CONCERNING MY HEALTH INFORMATION TO MYSELF: _____ MY PARENT/GUARDIAN: _____ OTHER: _____.

I UNDERSTAND THAT MY PERSONAL HEALTH INFORMATION WILL BE USED BY TUCSON PAIN INSTITUTE ACCORDING TO ARIZONA STATE AND HIPAA.

By signing this form, I agree and consent to Tucson Pain Institute's use and disclosure of my protected health information to conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly, and to conduct normal healthcare operations such as quality assessments and healthcare provider certifications as stated in the notice of privacy practices, and that I have been provided or offered a copy of this notice.

I agree that all of the above demographic and insurance information is accurate and up-to-date. If there is an error in the information above, I understand I am responsible for the charges related to the error(s). I understand and agree, regardless of my insurance status, that I am ultimately responsible for the balance of any professional services rendered. I understand that I am responsible for any charges incurred if my account is sent to a collection agency and for any returned checks. I understand that Medicare and/or other Insurance Carriers do not cover all office services/procedures. I agree to take full responsibility for any unpaid balances and that such payment will be made to the said assignee for services. I hereby assign all medical and/or treatment benefits including major medical benefits to Tucson Pain Institute for services rendered.

Patient Consent: _____ Parent/Legal Guardian's Consent: _____

Patient Bill of Rights and Responsibilities

As a patient, you have the right to:

- Considerate and respectful care.
- Knowledge of the name of the healthcare provider who has primary responsibility for coordinating the care, and the names and professional relationships of other healthcare providers who may see you.
- Receive as much information about any proposed treatment or procedure as you may need in order to give informed consent or to refuse this course of treatment. Except in emergencies, this information shall include a description of the procedure or treatment, the medically significant risks involved in this treatment, alternate courses of treatment or non-treatment and the risks involved in each and to know the name of the provider who will carry out the procedure or treatment.
- Participate actively in any decisions regarding your medical care; to the extent permitted by law, this includes the right to refuse treatment.
- Full consideration of privacy concerning your medical care. Case discussion, consultation, examination and treatment are confidential and should be conducted discreetly. You have the right to be advised as to the reason for the presence of any individual.
- Confidential treatment of all communications and records pertaining to your care.
- Reasonable continuity of care and to know, in advance, the time and location of appointment as well as the identity of persons providing care.
- Be advised if the healthcare provider proposes to engage in or perform human experimentation affecting care or treatment, you have the right to refuse to participate in such research projects.
- Have all your rights apply to the person who may have legal responsibility to make decisions regarding medical care on behalf of the patient.
- Have complaints forwarded to Administrative personnel for appropriate response.
- Know that all the Clinic/Office personnel will observe your rights.

The care a patient receives depends partially on the patient. Therefore, in addition to patient rights, you as the patient have certain responsibilities as well.

- You are responsible to provide accurate and complete information concerning your present complaints, past medical history, and other matters relating to your health.
- You are responsible for making it known whether you clearly comprehend the course of your medical treatment and what is expected of you.
- You are responsible for following the treatment plan established by your healthcare provider, including the instructions of nurses and other health professionals as they carry out the healthcare providers orders.
- You are responsible for keeping appointments and for notifying the office within 24 hours to cancel your appointment. We understand emergency situations occur, however, we reserve the right to initiate a $25.00 missed appointment fee per occurrence, with the possibility of dismissal after three occurrences.
- You are responsible for your actions should you refuse treatment or not follow the healthcare providers orders/recommendations.
- You are responsible for assuring that the financial obligations of your care are filled.
- You are responsible for being considerate of the rights of other patients and office personnel.

I understand my rights and responsibilities as a patient of Tucson Pain Institute:

Patient's Signature: _____ **Date:** _____ / _____ / _____

Witness: _____ **Date:** _____ / _____ / _____

Financial Policy and Waiver

Insurance Benefits

Arizona State Law requires that medical claims be paid by the insurance carrier within 30 days. As a courtesy we will bill your insurance carrier for all covered services. If your insurance has not appropriately paid the submitted claim within 45 days, all outstanding balances will become patient responsibility.

Insurance Co-Payments

In accordance with my insurance contract, I understand that co-payments are due at the time of service. This contractual obligation requires that the co-payment be made at the time of service, so it may be necessary to reschedule your appointment if your co-payment is not made.

Deductible

If my insurance deductible has not been met, I understand that full payment up to the total deductible amount will be collected at the time of service.

Co-Insurance

I understand that my plan may have co-insurance amounts and that I will be responsible for the co-insurance amount when my insurance has acknowledged my claim. I will be sent a statement for these amounts and understand that I will need to pay in full any co-insurance balances before any other procedures are scheduled.

Private Pay

If I have no insurance coverage, or insurance with which Tucson Pain Institute does not participate, full payment is expected at the time of service.

Verification of Benefits and Non-Covered Services

Insurance policies may differ per patient plan. Tucson Pain Institute may provide services that my insurance plan excludes. ***It is my responsibility to verify and understand my coverage benefits and exclusions.*** All non-covered services are my responsibility and are due at the time of service.

Collections

I understand that once an account is placed into collection status, all future services must be paid in full at the time of service. If my account is placed in collections, I will be responsible for all collection costs equal to 30% of my outstanding balance but no less than $25.00

No Show/Late Cancellations/Returned Checks

Cancellations made less than 24 hours in advance or "no show" appointments are subject to a $25.00 cancellation fee. These charges are my responsibility and will not be billed to my insurance carrier. Returned checks will be subject to a $25.00 returned check fee.

I have read and agree to abide by this financial policy and waiver.

Signature: _____ **Date:** _____ / _____ / _____

Tucson Pain Institute

AUTHORIZATION OF USE, INSPECTION AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Please note: Authorization is not valid unless it has been filled out completely.

Print Patient Name:_____ _____Date of Birth:_____

Street Address:_____

City, State, Zip Code:_____Telephone:_____

1. Information To Be Disclosed – Covering the periods of Health Care: (there may be a fee for copying these records)

From (date) _____ To (date) _____

- ☐ Discharge Summary
- ☐ History & Physical Exam
- ☐ Consultation Reports
- ☐ Laboratory Test Results
- ☐ Operative Report
- ☐ Other (please specify) :_____
- ☐ Progress Notes
- ☐ Itemized Bill
- ☐ Radiology Reports Only
- ☐ X-ray films only
- ☐ X-ray films/ CDs
- ☐ Continuity of Care Document (Allergies, Medications, Diagnostic Results, Problem List)

2. Purpose of Request:

- ☐ Treatment Consultation
- ☐ Insurance Copy
- ☐ Attorney
- ☐ Personal Copy
- ☐ Other:_____

3. To Be Released From

_____

_____

To Be Released To

Attn: _____

_____

4. Drug and/ or Alcohol Abuse, Communicable Disease, Psychiatric, and/or HIV/AIDS/Genetic Testing Records Release: I agree that any information regarding Drug and/or Alcohol Abuse, Communicable Disease, Psychiatric and/or Genetics Testing may be released. _____ No(initials)

agree that any medical or billing record containing information in reference to HIV/AIDS (Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome) testing and/or treatment may be released. _____ No(initials)

5. Time limit & Rights to Revoke Authorization:

I understand that I can revoke this authorization at any time by submitting a written notice to the Custodian of Records at the location where my records are located. However, I understand my records may have already been released.

6. Re-Disclosure/Treatment / Condition:

I understand the information disclosed by this authorization may be subjected to re-disclosure by the recipient and no longer be protected by the Health Insurance Portability and Accountability Act 1996. Tucson Pain Institute, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information. In understand I am not required to sign this authorization as a condition to obtain treatment, payment of services or eligibility for benefits.

7: Signature of Patient or Personal Representative Who May Request Disclosure:

Patient Signature: _____

Date:_____

Print:_____ Authority to Sign if not Patient:_____

8. Entity of Requestor Verified:

- ☐ Photo ID
- ☐ Matching Signature
- ☐ Other

The patient may be asked for urine and/or blood screening tests as well as random pill count. Failure to comply with this results in immediate discharge from the practice.
The patient understands that sharing of medications referred to above with anyone is absolutely forbidden and is against the law. Patient understands that the results of urine/blood testing can be given to the patient's other healthcare providers, insurance company, or other reimbursing agencies. The patient also authorizes any other healthcare provider, pharmacy, law enforcement, or judiciary body to release any pertinent information regarding the patient's prescription or urine/blood screen results. Patient agrees that any use of illicit substances (Marijuana, Cocaine, etc.) during treatment is strictly prohibited and if identified during a urine test it will result in discharge. The only exception is marijuana used for medicinal purposes and only when prescribed by a US licensed physician. I, the undersigned, attest that above was discussed with me, and I fully understand and agree to all of the above requirements and instructions. I also understand that failure to comply with above can result in my discharge from Advanced Pain Associates.

HIPPA NOTICE OF PRIVACY PRACTICES
HEALTH INFORMATION THAT WE MAINTAIN ABOUT YOU
We maintain records of:
1. Your name and (if different) the name and relationship of the person receiving treatment.
2. Your address
3. Your telephone number
4. Your (or the patient's, if different) condition
5. The date the doctor diagnosed the condition
6. Clinical findings related to the condition such as results of blood tests, procedures, examinations, and diagnostic modalities.
7. Your insurance and other coverage information such as billing records.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION
You have the right to:

- Request restrictions on certain uses and disclosures (we are not required to agree to the restriction)
- **Receive communications of protected health information by alternative means or at alternative locations such as home telephone numbers, cell phones, etc. We may leave messages at any or all telephone numbers listed by patient on the patient information form. We may contact any person left as an emergency contact listed on patient information form. We may contact the patient's spouse relaying any message regarding care, appointment or any necessary information deemed necessary for the patient's treatment or care.**
- Inspect copy and amend your protected health information held at Advanced Pain Associates.
- Receive an accounting of certain disclosures (of your protected health information)
- Receive a paper copy of this notice even if you have received it electronically.

HOW WE USE AND DISCLOSE YOUR HEALTH INFORMATION
We only use or disclose your health information as state and federal laws require or permit. In some cases, the law requires that you authorize the disclosure. In other cases, the law allows us to disclose your health information without your authorization.
Use and Disclosure Not Requiring Your Authorization
Treatment: We may use your health information for our treatment activities, such as disclosing it to other healthcare providers as helpful to treat you.
Payment: We may use and disclose your health information for our payment and collection activities, such as sending claims to insurance companies for the payment of metabolic treatment products.
Healthcare Operations: We may use and disclose your health information to manage our program operations, such as reviewing the quality of services you receive. Business Associates: We may disclose your health information to organizations that help us with our work, such as the billing service we use to process claims to your health

insurance company. We have a written agreement that requires these organizations to use your health information for only the reasons necessary to do the work, and protect it from other uses or disclosures, just like we do.
To Contact You: We may use the information in your health records to contact you if we have information about treatment or other health-related benefits and services that may be of interest to you.

Other Permitted Uses and Disclosures

HIPAA specifically permits us to use or disclose your health information for other purposes without your consent or authorization. In our experience such disclosures are rare, and the limited information we maintain is generally not applicable. However, when authorized by law, and to the extent we may have the information, HIPAA permits us to disclose it to:

- Comply with the requirements of federal, state, or local laws, court orders or other lawful process and for administrative or court proceedings
- report a public health authority for the purpose of preventing o r controlling disease, injury, or disability
- report to the FDA for the quality, safety or effectiveness of FDA-regulated products or activities
- notify a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition
- report abuse, neglect or domestic violence to a government authority
- provide necessary information to a health oversight agency for activities such as audits, investigations, inspections, licensure of the healthcare system, government benefit programs and regulated entities
- a law enforcement official for specified law enforcement purposes
- coroners or medical examiners for identification or determining cause of death
- funeral directors to carry out their duties with respect to the decedent
- organ procurement organizations for facilitating donation and transplantation researchers conducting studies approved by an Institutional Review Board
- prevent or lessen a serious and imminent threat to the health of safety of a person or the public
- authorized federal officials for specialized government functions such as military and veterans activities; national security and intelligence activities; protective services for the president; medical suitability determinations; correctional institutions; government entities providing public benefits and comply with workers' compensation laws

Phone Message/Call Authorization (means of communication via phone, fax, or email):
I, the undersigned, hereby authorize the staff of Advanced Pain Associates to leave messages on my answering machine or cell phone regarding my care or for appointment reminders or transmission of other information via fax and or e-mail.

Uses and Disclosures with Your Authorization
Other uses and disclosures or your personal information require your written authorization. You may revoke your authorization at any time by doing so in writing.
By signing this form I acknowledge that I have read and understood the contract agreement and will follow these instructions during my treatment. I have also received a copy of this agreement for my files.

Acknowledgement of Receipt of Notice of Privacy

/ /

Signature of Patient or Authorized Representative — Date

/ /

Printed Name of Patient or Authorized Representative — Date

/ /

Printed Name of Patient or Authorized Representative — Date

/ /

Relationship of Authorized Representative (if applicable) — Date

/ /

Wellness Signature — Date

Unable to obtain acknowledgement of receipts of Notice of Privacy Practices because:

/ /

Signature — Date

Tucson Pain Institute

1025 W. 24th St. Suite 26 • Yuma, AZ 85364
PH: 928.276.3049 • FX: 928.259.7006
Web: www.tpiaz.com

"No Show" and "Cancellation" Policy and Procedure For Office Visits and Procedures

At Tucson Pain Institute, our goal is to provide quality Pain Management care in a timely manner. We have implemented a NO SHOW and CANCELLATION POLICY which enables us to better utilize available appointments for our patients in need of Pain Management. The following policy is with regards to patients who fail to keep their scheduled office visit or procedure appointment.

Please be courteous and call Tucson Pain Institute promptly if you are unable to attend an appointment. This time will be reallocated to someone who is in urgent need of treatment. Available appointments are in high demand and your early cancellation will give another person the possibility to have access to timely Pain Management care.

- Patients who fail to show for their scheduled appointment or did not notify the office within 24 hours of their scheduled appointment time, shall be subject to a "NO SHOW/CANCELLATION" fee of $25.00. In the event of an actual emergency and prior notice could not be given, consideration will be given, and a one-time exception may be granted.

- Patients who fail to show for their scheduled office procedure appointment or did not notify the office within 48 hours of their scheduled appointment time, shall be subject to a "NO SHOW/CANCELLATION" fee of $50.00.

- These fees are not covered by Insurance and it therefore is the sole responsibility of the patient.

How to Cancel Your Appointment :

To cancel or reschedule appointments call Tucson Pain Institute 928-276-3049. If you have any problems getting through, you can leave a message with your Name and Date of Birth, Appointment Date and Cancellation Reason or Request for Rescheduling.

Patient Signature:_____ Date:_____

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 use of medication?	0 1 2 3 4

 The SOAPP® was developed with a grant from the National Institutes of Health and an educational grant from Endo Pharmaceuticals.

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.

COMM™

Please answer each question as honestly as possible. Keep in mind that we are only asking about the **past 30 days**. There are no right or wrong answers. If you are unsure about how to answer the question, please give the best answer you can.

Please answer the questions using the following scale:	**Never**	**Seldom**	**Sometimes**	**Often**	**Very Often**
	0	1	2	3	4
1. In the past 30 days, how often have you had trouble with thinking clearly or had memory problems?	O	O	O	O	O
2. In the past 30 days, how often do people complain that you are not completing necessary tasks? (i.e., doing things that need to be done, such as going to class, work or appointments)	O	O	O	O	O
3. In the past 30 days, how often have you had to go to someone other than your prescribing physician to get sufficient pain relief from medications? (i.e., another doctor, the Emergency Room, friends, street sources)	O	O	O	O	O
4. In the past 30 days, how often have you taken your medications differently from how they are prescribed?	O	O	O	O	O
5. In the past 30 days, how often have you seriously thought about hurting yourself?	O	O	O	O	O
6. In the past 30 days, how much of your time was spent thinking about opioid medications (having enough, taking them, dosing schedule, etc.)?	O	O	O	O	O

 The COMM™ was developed with a grant from the National Institutes of Health and an educational grant from Endo Pharmaceuticals.

PainEDU.org
IMPROVING PAIN TREATMENT THROUGH EDUCATION

Please answer the questions using the following scale:	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
7. In the past 30 days, how often have you been in an argument?	O	O	O	O	O
8. In the past 30 days, how often have you had trouble controlling your anger (e.g., road rage, screaming, etc.)?	O	O	O	O	O
9. In the past 30 days, how often have you needed to take pain medications belonging to someone else?	O	O	O	O	O
10. In the past 30 days, how often have you been worried about how you're handling your medications?	O	O	O	O	O
11. In the past 30 days, how often have others been worried about how you're handling your medications?	O	O	O	O	O
12. In the past 30 days, how often have you had to make an emergency phone call or show up at the clinic without an appointment?	O	O	O	O	O
13. In the past 30 days, how often have you gotten angry with people?	O	O	O	O	O
14. In the past 30 days, how often have you had to take more of your medication than prescribed?	O	O	O	O	O
15. In the past 30 days, how often have you borrowed pain medication from someone else?	O	O	O	O	O
16. In the past 30 days, how often have you used your pain medicine for symptoms other than for pain (e.g., to help you sleep, improve your mood, or relieve stress)?	O	O	O	O	O

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Please answer the questions using the following scale:	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
17. In the past 30 days, how often have you had to visit the Emergency Room?	O	O	O	O	O