Alamance Regional Medical Center

1240 Huffman Mill Road
Burlington, NC 27216
Pain Management Centers
Medication Assessment Form

Pain Medication Assessment Form - Initial

Instructions: **Please circle "Yes" or "No", depending on the answer to each question.**

Analgesia Assessment: **(Circle the number that most closely resembles your level of pain)**

Without pain medicine? **(No pain) 0 1 2 3 4 5 6 7 8 9 10 (worse pain)**
With the medicine? **(No pain) 0 1 2 3 4 5 6 7 8 9 10 (worse pain)**

Yes **No** **Item 1:** Are your pain medications helping **decrease** your pain?
Yes **No** **Item 2:** Are you taking your medications as prescribed or directed by our pain physician?
Yes **No** **Item 3:** Do you continue to have the chronic pain for which you were given your pain medication(s)?

Activity Assessment:

Yes **No** **Item 4:** Has your pain medication(s) helped increase or improve your level of activity? Does taking pain medicine allow you to do more?
Yes **No** **Item 5:** Does your medication help you accomplish **basic** activities of daily living? (Bathing, dressing and undressing, eating, transferring from bed to chair and back, voluntarily control your urine and bowel movements, using the toilet, and walking)
Yes **No** **Item 6:** Does your medication help you accomplish **instrumental** activities of daily living? (Light housework, preparing meals, taking medications, shopping for groceries or clothing, using the telephone, and managing money)
Yes **No** **Item 7:** Does your medication help you accomplish **occupational** activities of daily living? (Care for others, care for pets, child rearing, communication device use, community mobility, financial management, health management and maintenance, meal preparation and cleanup, safety procedures and emergency responses, and shopping)
Yes **No** **Item 8:** Does your medication help you accomplish **work-required** activities?

Adverse Effect(s) Assessment:

Yes **No** **Item 9:** Are you and your family aware and understand that **narcotic** pain medications can be **addictive** and habit forming?
Yes **No** **Item 10:** Are you and your family aware and understand that these **narcotic** pain medications can cause **death** if taken inappropriately, if taken with alcohol, or if taken in combination or in addition to other narcotics, over-the-counter medications, or illegal drugs?
Yes **No** **Item 11:** Are you and your family aware and understand that the **possible side-effects** of these medications include, but are not limited to: allergic reactions (difficulty breathing; closing of your throat; swelling of your lips, tongue, or face; or hives); slow, weak breathing; seizures; cold clammy skin; severe weakness or dizziness; unconsciousness; yellowing of the skin or eyes; unusual fatigue, bleeding, or bruising; constipation; dry mouth, nausea, vomiting, or decreased appetite; tiredness, or lightheadedness; muscle twitches; sweating; itching; decreased urination; or decreased sex drive and impotence?
Yes **No** **Item 12:** Are you and your family aware that everybody is different and that the same dose that provides you with pain relief may be sufficient to cause **death** to another human being, especially children?
No **Yes** **Item 13:** Are you having any **side-effects** to your pain medication?
Please circle your side-effect(s): Nausea, vomiting, constipation, difficulty breathing, being too sleepy, lack of coordination, mental impairment, allergic reactions, Other (Please specify):_____

Medication Compliance Assessment:

No **Yes** **Item 14:** Are you taking more medication than prescribed?
No **Yes** **Item 15:** Are you using, or have you used any illegal substances in the past month? (Marijuana, cocaine, heroine, amphetamines, PCP, etc.)
No **Yes** **Item 16:** Are you sharing your medications with anyone?
No **Yes** **Item 17:** Are you, your family, or anyone else selling your medications to anyone?
No **Yes** **Item 18:** Are you getting any pain medications or pain medication prescriptions from any other physician, dentist, or any other sources other than your pain physician at this office?
No **Yes** **Item 19:** Do you go to any other pain clinic(s)?
No **Yes** **Item 20:** Are you buying pain medications from the internet, other patients, street drug dealers, or any other sources, other than a licensed pharmacy?
No **Yes** **Item 21:** Are you or have you used more than one pharmacy in the past month?
No **Yes** **Item 22:** Do you have any other pain medication or pain medication prescription at home, other than what we have prescribed to last until the end of this month?
No **Yes** **Item 23:** Do you have any surplus narcotic pain medication left at home at the end of every month?

Medico-legal Assessment:

Yes **No** **Item 24:** Have you received a copy of our "**Pain Program Medication Policy**"?
Yes **No** **Item 25:** Have you read the "**Pain Program Medication Policy**"?
Yes **No** **Item 26:** Have you read and signed our "**Medication Agreement**", and "**Medication Informed Consent**"?
No **Yes** **Item 27:** Do you have any questions about the "**Pain Program Medication Policy**", "**Medication Agreement**", or the "**Medication Informed Consent**"?
No **Yes** **Item 28:** Do you have any **wish to harm yourself or others**?

Patient - I certify that all of the above questions have been answered truthfully. I also understand that not answering truthfully constitutes an act of deception on my part that may result in my dismissal from this pain program.

_____
Patient's Signature Date

Healthcare Provider – The following items were addressed today:

_____
Healthcare Provider Signature - Date