Alamance Regional Medical Center

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

Pain Medication Assessment Form

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** **1.** Are your pain medications helping **decrease** your pain?
Yes **No** **2.** Are you taking your medications as prescribed and directed by our pain physician?
Yes **No** **3.** Do you continue to have the pain for which you were given your pain medication?

Activity Assessment:

Yes **No** **4.** Does taking pain medicine allow you to do more and be more active?
Yes **No** **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** **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** **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** **8.** Does your medication help you accomplish **work-required** activities?

Adverse Effect(s) Assessment:

Yes **No** **9.** Are you and your family aware and understand that **narcotic** pain medications can be **addictive** and habit forming?
Yes **No** **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** **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** **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?
Yes **No** **13.** Are you **free of side-effects** from your pain medication? **If not, please circle the appropriate:** Nausea, vomiting, constipation, difficulty breathing, being too sleepy, lack of coordination, difficulty thinking or remembering, allergic reactions, Other (Please specify):

Medication Compliance Assessment: (Since your last visit to our office.)

No **Yes** **14.** Have you taken more medication than prescribed?
No **Yes** **15.** Have you used any illegal substances? (Marijuana, cocaine, heroin, Methamphetamines, PCP, etc.)
No **Yes** **16.** Have you shared or given away any of your medication?
No **Yes** **17.** Are you or anyone else selling your medication?
No **Yes** **18.** Have you received pain medication from any other sources other than from this office?
No **Yes** **19.** Have you gone to any other pain specialist?
No **Yes** **20.** Are you buying pain medication from any other source, other than a local licensed pharmacy?
No **Yes** **21.** Have you used more than one pharmacy?
No **Yes** **22.** Do you have spare pain medication left at home, other than what you brought to the clinic today?
No **Yes** **23.** Do you have any pain pills left at the end of every month?

Medico-legal Assessment:

No **Yes** **24.** Do you need a copy of our "**Pain Program Medication Policy**"?
No **Yes** **25.** Do you have any questions about the "**Pain Program Medication Policy**", "**Medication Agreement**", or the "**Medication Informed Consent**"?
No **Yes** **26.** 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 Notes:

Healthcare Provider Signature - Date