Alamance Regional Medical Center

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

Chronic Opioid Use Assessment Form – Established Patient Follow-up

Instructions: Please circle the appropriate answer to each question.

Analgesia Assessment:

What is your pain like, **without** pain medicine? (No pain) **0 1 2 3 4 5 6 7 8 9 10** (worse pain)
What is your pain like, **with** the medicine? (No pain) **0 1 2 3 4 5 6 7 8 9 10** (worse pain)

Yes No **Effectiveness:** Are your pain medications helping decrease your pain?
Yes No **Compliance:** Are you taking your medications as prescribed?
Yes No **Indication:** Do you continue to have chronic pain?

Activity of Daily Living (ADL) Assessment:

Yes No **General:** Does taking pain medicine allow you to be more active?
Yes No **Basic ADL:** Does taking pain medication help you with bathing, dressing and undressing, eating, transferring from bed to chair and back, using the toilet, and walking?
Yes No **Instrumental ADL:** Does taking pain medication help you with light housework, preparing meals, shopping for groceries or clothing, using the telephone, and managing money?
Yes No **Occupational ADL:** Does taking pain medication help you with the care for others, care for pets, child rearing, using the phone, moving about the community, financial management, health management and maintenance, meal preparation and cleanup, safety procedures and emergency responses, and shopping?
Yes No **Work-related ADL:** Does taking pain medication help you accomplish work-required activities?

Adverse Effect(s) Assessment: (*Related to opioid pain medication use*.)

No Yes **Addiction:** Do you find yourself craving for the use of pain medicine despite not having pain severe enough to warrant it?
No Yes **Side-effects:** (Circle appropriate) Since your last visit, have you experienced any of the following?
Allergic reactions; difficulty breathing; closing of your throat; swelling of your lips, tongue, or face; hives; slow, weak breathing; seizures; cold clammy skin; severe weakness; dizziness; unconsciousness; yellowing of the skin or eyes; unusual fatigue; bleeding; bruising; severe constipation; dry mouth; nausea; vomiting; decreased appetite; tiredness; lightheadedness; muscle twitching; profuse sweating; itching; decreased urination; decreased sex drive; impotence; difficulty walking.
No Yes **Cognitive impairment:** (Circle appropriate) Since your last visit, have you experienced any of the following?
Difficulty staying awake; lack of coordination; memory impairment.

Aberrant Behavior Assessment:

No Yes **Overdose Risk:** Have you taken more medication than prescribed?
No Yes **Misuse or Abuse:** Have you consumed any alcohol while taking pain medication?
No Yes **Use of illegal substances:** Have you taken any illegal drugs, including "medical marijuana", since your last visit?
No Yes **Felony Distribution:** Are you sharing your medications with anyone?
No Yes **Felony Drug Dealing:** Are you or anyone else selling your medication?
No Yes **Doctor Shopping:** Have you obtained pain medication from any other healthcare provider other than us, since your last visit?
No Yes **Mismanagement Risk:** Do you go to any other pain clinic(s)?
No Yes **Felony Procurement:** Have you obtained pain medication from any other sources, other than a local licensed pharmacy?
No Yes **Non-compliance with office regulations:** Are you or have you used more than one pharmacy in the past month?
No Yes **Hoarding:** Do you have any surplus narcotic pain medication left at home at the end of every month?

Psychological Assessment:

No Yes 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 -

Healthcare Provider Signature Date