

SOAPPSM VERSION 1.0

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

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| 1. How often do you feel that your pain is “out of control?” | 0 | 1 | 2 | 3 | 4 |
| 2. How often do you have mood swings? | 0 | 1 | 2 | 3 | 4 |
| 3. How often do you do things that you later regret? | 0 | 1 | 2 | 3 | 4 |
| 4. How often has your family been supportive and encouraging? | 0 | 1 | 2 | 3 | 4 |
| 5. How often have others told you that you have a bad temper? | 0 | 1 | 2 | 3 | 4 |
| 6. Compared with other people, how often have you been in a car accident? | 0 | 1 | 2 | 3 | 4 |
| 7. How often do you smoke a cigarette within an hour after you wake up? | 0 | 1 | 2 | 3 | 4 |
| 8. How often have you felt a need for higher doses of medication to treat your pain? | 0 | 1 | 2 | 3 | 4 |
| 9. How often do you take more medication than you are supposed to? | 0 | 1 | 2 | 3 | 4 |
| 10. How often have any of your family members, including parents and grandparents, had a problem with alcohol or drugs? | 0 | 1 | 2 | 3 | 4 |
| 11. How often have any of your close friends had a problem with alcohol or drugs? | 0 | 1 | 2 | 3 | 4 |