

BIRTH & FAMILY CLINIC

21911 76th Ave. W., Suite 110 Edmonds, WA 98026

Phone: 425-640-4950 Fax: 425-640-4958

www.birthandfamilyclinic.com

Patient Name: _____ DOB: _____

Date of Visit: _____ Age: _____

Pain Assessment

Each patient's pain threshold is unique. The type of pain you feel may not be the same as someone else's. To help us better understand your pain, we ask that you rate your pain on a scale of zero to 10, where zero equals no pain and 10 equals the worst.

1. Least pain level in the last two weeks:

0 1 2 3 4 5 6 7 8 9 10

2. Average pain level in the last two weeks:

0 1 2 3 4 5 6 7 8 9 10

3. Worst pain level in the last two weeks:

0 1 2 3 4 5 6 7 8 9 10

4. Today's pain level:

0 1 2 3 4 5 6 7 8 9 10

Functional Assessment

For each of the 7 categories of life activity listed below, pick the number that best describes how much your pain interferes with your ability to perform the activity (0 = no disability; 10 = total disability).

1. Family/home responsibilities (chores, yard work, child care):

0 1 2 3 4 5 6 7 8 9 10

2. Recreation (hobbies, sports, leisure activity):

0 1 2 3 4 5 6 7 8 9 10

3. Social activity (with friends, includes parties, dining out):

0 1 2 3 4 5 6 7 8 9 10

4. Occupation (work and non-paying jobs):

0 1 2 3 4 5 6 7 8 9 10

5. Sexual behavior (frequency and quality of sex life):

0 1 2 3 4 5 6 7 8 9 10

6. Self-care (showering, driving, dressing):

0 1 2 3 4 5 6 7 8 9 10

7. Life-support activity (eating, sleeping, breathing):

0 1 2 3 4 5 6 7 8 9 10

In your own words (without using the word "pain"), how will we know that a treatment is working for you?

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Screener and Opioid Assessment for Patients with Pain (SOAPP)[®] Version 1.0-14Q

The following are some questions given to all patients at the Birth & Family Clinic 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.

	Never	Seldom	Some- times	Often	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
11. How often have you felt a craving for medication?	0	1	2	3	4
12. How often have you been asked to give 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.

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The Patient Health Questionnaire (PHQ-9)

Patient Name: _____ DOB: _____

Date of Visit: _____ Age: _____

When thinking about drug use, include illegal drug use and the use of prescription drug use other than prescribed.

Over the past 2 weeks, how often have you been bothered by any of the following problems?

	Not At All	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling asleep, staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you’re a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or, the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

Column Totals: _____ + _____ + _____

Add Totals Together: _____

10. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all Somewhat difficult Very difficult Extremely difficult

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Generalized Anxiety Disorder 7 (GAD-7)

Patient Name: _____ DOB: _____

Date of Visit: _____ Age: _____

The GAD-7 is a brief clinical measure for the assessment of generalized anxiety disorder. This tool may serve as a screening instrument to identify probable cases of GAD, and the scale scored provide a measure of severity.

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not At All	Several Days	More Than Half the Days	Nearly Every Day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

Column Totals: _____ + _____ + _____

Add Totals Together: _____

8. If you checked off any problem, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all Somewhat difficult Very difficult Extremely difficult

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Int Med.* 2006;166:1092-1097. .

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Patient Name: _____ DOB: _____

Date of Visit: _____ Age: _____

The Mood Disorder Questionnaire (MDQ)

Please answer each question as best as you can.

1. Has there ever been a period of time when you were not your usual self and...			
- You felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	Yes	No	
- You were so irritable that you shouted at other people or started fights or arguments?	Yes	No	
- You felt so much more self-confident than usual?	Yes	No	
- You got much less sleep than usual and found that you didn't really miss it?	Yes	No	
- You were more talkative or spoke much faster than usual?	Yes	No	
- Thoughts raced through your head or you couldn't slow your mind down?	Yes	No	
- You were so easily distracted by things around you that you had trouble concentrating or staying on track?	Yes	No	
- You had much more energy than usual?	Yes	No	
- You were much more active or did many more things than usual?	Yes	No	
- You were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	Yes	No	
- You were much more interested in sex than usual?	Yes	No	
- You did things that were unusual for you or that other people might have thought were excessive, foolish or risky?	Yes	No	
- Spending money got you or your family in trouble?	Yes	No	
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	Yes	No	
3. How much more of a problem did any of these cause you – like being able to work; having family; money or legal troubles; getting into arguments or fights?			
No Problem	Minor Problem	Moderate Problem	Serious Problem
4. Have any of your blood relatives (i.e., children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	Yes	No	
5. Has a health professional ever told you that you have manic-depressive illness or a bipolar disorder?	Yes	No	

Designed for screening purposes only and is not to be used as a diagnostic tool.

Scoring: All three of the following criteria must be met for a positive screen:

Question 1:
7 of 13 positive (yes) responses

+ Question 2:
Positive (yes) response

+ Question 3:
“moderate” or “serious” response

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CAGE-AID Questionnaire

Patient Name: _____ DOB: _____

Date of Visit: _____ Age: _____

When thinking about drug use, include illegal drug use and the use of prescription drug use other than prescribed.

Questions:	YES	NO
1. Have you ever felt that you ought to cut down on your drinking or drug use?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have people annoyed you by criticizing your drinking or drug use?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever felt bad or guilty about your drinking or drug use?	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?	<input type="checkbox"/>	<input type="checkbox"/>