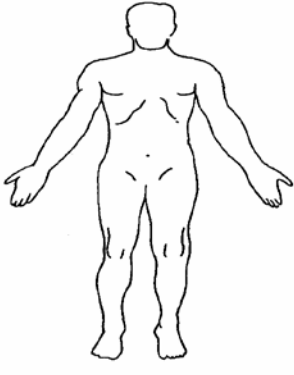
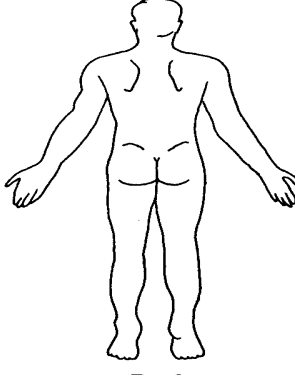


**SUBOXONE FOLLOW UP  
 QUESTIONNAIRE**

Name (last) \_\_\_\_\_ (first) \_\_\_\_\_ DOB \_\_\_\_\_ Age \_\_\_\_\_ Sex: Male Female

**CURRENT SYMPTOMS** Please mark the location(s) of your pain with an "X" and show where it goes with an arrow.

If whole areas are painful, shade in the painful area. Circle the words which best describe you pain.

sharp	 <i>Front</i> right left	shooting	 <i>Back</i> left right	burning
throbbing		electric-like		skin sensitivity to light touch, cold
cutting		pins and needles		abnormal swelling, hair/nail growth
dull, aching		weakness		abnormal sweating
pressure		numbness		abnormal skin color changes
muscle pain				abnormal skin temperature
cramping				limited movement

Do you have this pain:  constantly (90-100% of the time),  frequently (75%),  intermittently (50%),  occasionally (25%)

<b>Pain Intensity:</b> Circle your pain intensity with "0" representing no pain and "10" the most severe pain imaginable	Current	None	0	1	2	3	4	5	6	7	8	9	10	Severe
	Least pain score the last 7 days	None	0	1	2	3	4	5	6	7	8	9	10	Severe
	Worst pain score the last 7 days	None	0	1	2	3	4	5	6	7	8	9	10	Severe
	With medications	None	0	1	2	3	4	5	6	7	8	9	10	Severe
	Without medications	None	0	1	2	3	4	5	6	7	8	9	10	Severe

Please list ALL medications from all providers and mark refills you'll need before your next visit

Medication	Dose	How many at a time	How many times a day	Benefits/ side effects	Last intake?	Refill needed?

Prior injections or procedures

DATE	NAME OF PROCEDURE	HOW MUCH PAIN RELIEF?	FOR HOW LONG?	SIDE EFFECTS
1.		%		
2.		%		

Comments/Goals for this appointment: \_\_\_\_\_

Have there been any significant changes in your health or pain control since your last visit?  No  Yes, if yes explain: \_\_\_\_\_

Were you able to increase your activities?  Yes  No      Were you able to decrease your intake of pain medication?  Yes  No

**Activity Scale (Circle)** Work full time/ Work part time/ Able to leave home without help/ Require help to leave home/ House confined

I sleep in \_\_\_\_\_ hour increments, for a total of \_\_\_\_\_ hours in a 24 hour period.      Do you feel rested?  Yes  No

What makes your pain worse? \_\_\_\_\_

What makes your pain better? \_\_\_\_\_

Daily activities: \_\_\_\_\_

Weekly activities: \_\_\_\_\_

What do you do to improve your pain control? \_\_\_\_\_

What are your goals with treatment? \_\_\_\_\_ Are we helping you meet your goals?  Yes  No

Is constipation a problem?  Yes  No      Do you feel depressed?  Yes  No

Do you use alcohol?  No  Yes If yes, list frequency/ amount: \_\_\_\_\_

Do you use marijuana or any other recreational drugs?  No  Yes \_\_\_\_\_

When did you take your last dose of opioid? \_\_\_\_\_

Are you pregnant?  N/A  No  Not sure  Yes \_\_\_\_\_