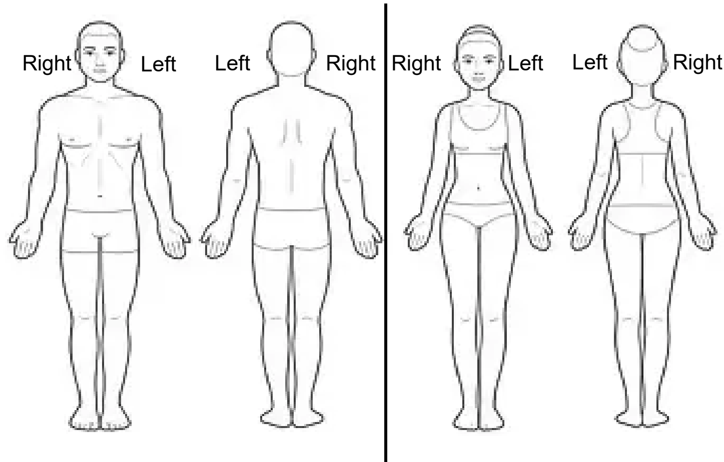
The Smarter Choice for Care
Middlesex Health

Patient Name: ______________________ **Date of Birth:**__________ **Date:** __________

1. What type of pain do you have?
____
____

2. Circle the location of your pain:



3. Does the pain radiate (move) to any other location of your body?

NO / YES

If yes, where: ______________________________

4. Describe the type of pain (Circle ALL that apply)

SHARP STABBING DULL ACHY
BURNING CRUSHING THROBBING
SHOOTING TWISTING STRETCHING

5. When did the pain start? ____________________
____

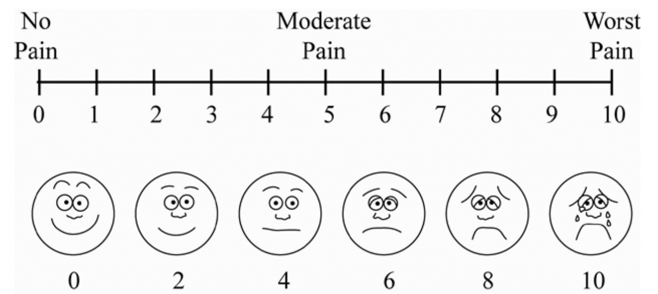
6. Is the pain constant? YES / NO
If no, indicate the frequency
____
(e.g. times per day or per week)

7. Circle things that make the pain better
(Circle ALL that apply)
HEAT ICE PHYSICAL THERAPY
MASSAGE REST POSITION CHANGES
MEDICATION Other: ______________________
____

8. Does anything make the pain worse? NO /YES
If yes, describe:
____
____

9. Please list any additional symptoms you have with the pain: ______________________________
____

10. Please circle the severity of the pain on the scale below:



11. Does your pain interfere with any of the following:
(Circle ALL that apply)

WALKING MOOD SLEEP
SEXLIFE WORK TOILETING
BATHING DRESSING EATING
PREPARING MEALS HOUSEWORK
RELATIONSHIPS GETTING OUT OF BED

12. List current pain medications (including prescription, over-the-counter medications and supplements)
____
____

13. Current medication side effects? NO YES
If yes, describe: ____________________________

14. List other pain medications previously tried (including prescription, over-the-counter medications and supplements)
____
____

15. Goals of treatment
____
____

Provider signature: ________________*Date reviewed:* __________

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Opioid Risk Tool (ORT)

		Mark each box that applies
Family History of Substance Abuse	Alcohol	☐
	Illegal Drugs	☐
	Prescription Drugs	☐
Personal History of Substance Abuse	Alcohol	☐
	Illegal Drugs	☐
	Prescription Drugs	☐
Age (mark box if 16-45)		☐
History of Preadolescent Sexual Abuse		☐
Psychological Disease	Attention Deficit Disorder	☐
	Obsessive Compulsive Disorder	☐
	Bipolar	☐
	Schizophrenia	☐
	Depression	☐

Total ☐

Reference: Webster LR. Predicting aberrant behaviors in opioid-treated patients: Preliminary validation of the opioid risk tool. *Pain Medicine.* 2005; 6(6):432-442.

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STOP-BANG Sleep Apnea Questionnaire

Chung F et al Anesthesiology 2008 and BJA 2012

STOP		
Do you **S**NORE loudly (louder than talking or loud enough to be heard through closed doors?	Yes	No
Do you often feel **T**IRED, fatigued or sleepy during the daytime?	Yes	No
Has anyone **O**BSERVED you stop breathing during your sleep?	Yes	No
Do you have or are you being treated for high blood **P**RESSURE?	Yes	No

BANG		
BMI more than 35 kg/m2?	Yes	No
AGE over 50 years old?	Yes	No
NECK circumference >16 inches (40cm)?	Yes	No
GENDER: Male?	Yes	No

TOTAL SCORE		

High Risk of OSA: Yes 5-8

Intermediate Risk of OSA: Yes 3-4

Low Risk of OSA: Yes 0-2

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Patient Health Questionnaire (PHQ-9)

Over the last 2 weeks how often have you been bothered by any of the following problems? (Please circle the number to indicate your answer for each item)

	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 or 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 are 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 hurting yourself in some way	0	1	2	3

TOTAL SCORE:

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Patient Name: ______________________________ Date of Birth: ___________ Date: __________

STABLE RESOURCE TOOLKIT

CAGE – AID Questionnaire

Patient Name: ____________________________

Date of Visit: _____________

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?		
2.) Have people annoyed you by criticizing your drinking or drug use?		
3.) Have you ever felt bad or guilty about your drinking or drug use?		
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?		

Permission for use granted by Richard Brown, MD.

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Patient Name: ______________________________ Date of Birth: ___________ Date: __________

Controlled Substance Agreement and Informed Consent Form

This is an agreement between me and my Primary Care Provider (PCP). It includes what I must do so my PCP can safely prescribe controlled medicine to me. It also includes reasons why my PCP will STOP prescribing controlled medicine.

I will get controlled medicine from my PCP only and fill prescriptions at the same pharmacy.

- I will only get my controlled medicine from my PCP:____________________.
- I will get all my controlled medicine from the same pharmacy.
- I will tell my PCP right away if I need to change pharmacies.

I will tell my PCP if another Provider treats me.

- I will tell my PCP when any other Provider treats me or prescribes me medicine.

I will tell my PCP if I have a bad side effect.

- I will tell my PCP if I have any bad side effects from the medicine I take.

I will call my PCP if I get pregnant.

- I will tell my PCP right away if I am pregnant or become pregnant.

I will take my medicine as prescribed.

- I will take my medicine only as my PCP prescribes.
- I will not take more than my PCP tells me, even if I feel like I should.

I will keep my medicine safe.

- I will keep my medicine safe and securely stored. My medicine can harm or kill people who may not be able to take it, like children, teenagers, and older adults. My medicine can also harm or kill pets.

I will drive or use machines safely.

- I will not drive or use a machine if sedated or when my PCP tells me it is unsafe.

I give my PCP permission to see all of my medical records.

- I give my PCP permission to see my medical records from every Provider who is treating me.

I agree to pill counts and drug testing.

- I agree to let my PCP count my pills and test my urine (pee) for drugs when asked to make sure I am taking my medicine as prescribed.

_____________ _____________
Initials Date

Patient Name: ______________________________ Date of Birth: ___________ Date: __________

I understand the risk of dependence and addiction with use of controlled medications.

- I understand that I can become physically dependent on the medication and can develop withdrawal symptoms if the medication is stopped suddenly or dose reduced quickly.
- I understand that there is a small chance of developing an addiction to a controlled medication which can cause a loss of control with the medication use.

I understand that there may be non medication treatments that my provider may recommend and I agree to participate if recommended.

- I agree to participate in other treatment types that are recommended to help improve symptoms.
- These could include physical therapy, exercise programs, behavioral therapy, injections, visits to specialists, etc.

I will follow refill requirements.

- I will ask for refills ONLY during normal office hours.
- I will ask for a refill before I run out of my controlled medicine. I will ask for a refill at least 48 business hours before I will run out of my medicine.
- I will only get a refill if I make and keep my appointments every 3 months, or sooner.
- I will be careful to keep track of my controlled medicine.
- I will NOT get a refill if my medicine is lost or stolen. No exceptions.

I agree that my PCP will STOP prescribing controlled medicine and wean me off if I:

- do NOT follow this agreement.
- get controlled medicine from any other Provider without telling my PCP.
- take more medicine than my PCP tells me, even if I feel like I need it.
- take my medicine in some other way, like by needle or by snorting.
- change my medicine in any way, like crushing or chewing tablets.
- use alcohol or any illegal (street) drugs like cocaine, fentanyl, heroin, or crystal meth.
- share, sell, trade, or exchange my medicine for money, goods, or services.
- find medication is ineffective or have side effects with use.

Pharmacy: ____________________________________ Telephone: ______________________

Patient Name (Printed): __________________________ Date of Birth: ____________________

Patient Signature: ______________________________ Date: __________________________

PCP Signature: ________________________________ Date: __________________________