110 Dutchman Court
Elkin NC 28621
Ph: 336.835.5330 Fax: 336.835.5337

Welcome New Patient:

Welcome to Revival Pain Management. Thank you for taking the time to get to know us. We have been serving Northwest NC and Southwest Virginia for seventeen years as a comprehensive pain program in the tri-state area. We have offices in Elkin, NC, North Wilkesboro, NC and Mount Airy, NC. Our Board Certified providers have over 55 years combined experience with medical and interventional management of pain disorders to help meet a variety of pain care needs.

At Revival Pain Management, we recognize that any form of chronic pain can make life challenging, even in the day to day tasks. This pain can originate from injuries, surgeries, disease and other life events. Our physicians and staff will work personally with you to offer a personalized treatment plan to help you with your pain concerns from diagnosis and evaluation to completion of your treatment process.

At Revival Pain Management we perform fluoroscopic guided interventional pain management procedures. Our office operates with a full service CLIA certified High Complexity laboratory on site that performs Urine Drug Screening, Hematology and Chemistry Studies. We have a physician Board Certified in Addiction Medicine by the American Society of Addiction Medicine. The Pain Management clinic is certified to use Buprenorphine in office detox. We believe in offering top quality facilities, procedures and techniques to create a care plan that will help you live to each day to the fullest.

ADMISSION ASSESSMENT/HISTORY & PHYSICAL

(Please use black or blue ink; do not use pencil)

Date: ___________ **Patient Name:** ________________________________ **Date of Birth:** _____________ **Age:** _____

What is your preferred language for discussing your healthcare? English ☐ Spanish ☐ Other ☐ _______________

Do you have an Advance Directive? Yes ( ) No ( ) If "No", would you like information on Advance Directives? Yes ( ) No ( )

Referring Physician ________________________________ Phone ( ) _______________

Primary Care Physician ______________________________ Phone ( ) _______________

Where is the primary site of your pain? ____

1. How long have you had this pain? Years ______ Months ______
2. Is your pain due to an injury? Yes _____ No _____ If yes, please explain ______________________

   ____
3. Does your pain radiate into any other parts of your body? Yes _____ No _____

   If yes, where does your pain radiate? ____________________________________

   ____
4. Is your pain? Infrequent _____, Intermittent _____, Constant _____, Increased with activity_____ 5. Check Yes or No to the following:
   a. Change in bowel control? Yes_____ No _____
   b. Change in bladder control? Yes_____ No _____
   c. Any color change or temperature change at your pain site? Yes _____ No _____
   d. Do you experience weakness? Yes_____ No_____
   e. Do you experience tingling? Yes _____ No_____ or burning pain Yes_____ No_____
   f. Do you experience swelling? Yes _____ No_____
   g. Does the pain interrupt sleep? Yes _____ No_____
   h. What makes your pain worse? (Any activity, prolonged standing, prolonged walking, bending, etc.)

      other:____
   i. What makes your pain better? (lying down, sitting, rest, heat, medication, etc.)

      other:____
   j. What pain medication have you had in the past?

      ____
   k. Have you ever had Nerve Blocks for this pain? Yes _____ No _____
   l. Have you ever had Tens/Nerve Stimulator for this pain? Yes _____ No _____
   m. Have you ever had Physical Therapy for this pain? Yes _____ No _____
   n. Do you use a cane, wheelchair, crutches, or a brace? No______ If Yes, describe ___________

6. Do you have a history of falls? No_____ Yes_____ [Please explain:] ______________________

NAME: ______________________________ DATE OF BIRTH ______________

Review of Systems: Do you have now or have had in the past year?

Condition	No	Yes	Present now?	In the past year?
Fever				
Weight Loss				
Vision Problems				
Hearing Problems				
Chest Pain				
Arm Pain				
Jaw Pain				
Irregular Heart Beat				
Stomach Pain				
Heartburn				
Diarrhea				
Constipation				
Rectal Bleeding				
Black Tarry Stools				
Urinary Frequency				
Urinary Burning				
Blood in urine				
Swollen/painful joints				
Yellow skin				
Skin Lesions/Ulcers				
Neck Swelling				
Shortness of Breath				
Coughing up blood				
Blackouts				
Anxiety				
Depression				
Bleeding Problems				

Past Medical History: Have you had any of the following?

Check	No	Yes	Check	No	Yes	Check	No	Yes	Check	No	Yes
Heart Disease			Rheumatic Fever			Depression			Kidney Stone		
Enlarged Heart			Rheumatoid Arthritis			Lupus			Stroke		
Heart Murmur			Arthritis			Anesthesia sensitivity			Epilepsy		
Hypertension			Emphysema			Lung Disease			Convulsion		
Phlebitis			Pneumonia			Gall Bladder					
Blood Clot			Tuberculosis			Stomach Ulcer					
Cancer			Pleurisy			Hepatitis					
Back Disorder			Thyroid			Liver Disease					
Diabetes			Anxiety			Kidney Infection					

NAME: ______________________________ DATE OF BIRTH ____________

List Past Surgery:

1. ______________________ 5. ______________________
2. ______________________ 6. ______________________
3. ______________________ 7. ______________________
4. ______________________ 8. ______________________

List Medication Allergies and Reactions

1. ______________________ Reaction: ______________________
2. ______________________ Reaction: ______________________
3. ______________________ Reaction: ______________________
4. ______________________ Reaction: ______________________

List Medications:

Name	Strength	Dose	Name	Strength	Dose

Do you have a family history (Mother, Father, Brother, Sister, Aunt, or Uncle) of the following:

Heart Disease ____ High Blood Pressure _____ Diabetes _____ Stroke _____ Cancer _____ Thyroid ______

Anesthesia Problems/Sensivity _____

Please check each question that applies to you: Do you exercise regularly ______ Smoke: (if yes how much?)________

Use Alcohol: (if yes how much?) ___________ Use Illegal drugs _____

Have you ever had to visit the Emergency Room for overdose or pain ( ) Yes ( ) No Have you ever been admitted to the hospital for overdose or pain? ( ) Yes ( ) No Did that admission require a stay in the ICU? ( ) Yes ( ) No

Do you have a history of participation in an alcohol or substance abuse treatment program? ( ) Yes ( ) No If yes, please list the facility name, alcohol or substance used, length of treatment)

Do you have a history of abuse or neglect? No ( ) Yes ( ) If 'yes' then please explain:

____

NAME: ______________________________ DATE OF BIRTH ________________

Some of the words below describe your pain **today**. If a word describes your pain **today,** check the intensity of that sensation. Otherwise check "0" for no pain.

	None	Mild	Moderate	Severe
THROBBING	0)___	1)___	2)___	3)___
SHOOTING	0)___	1)___	2)___	3)___
STABBING	0)___	1)___	2)___	3)___
SHARP	0)___	1)___	2)___	3)___
CRAMPING	0)___	1)___	2)___	3)___
GNAWING	0)___	1)___	2)___	3)___
HOT-BURNING	0)___	1)___	2)___	3)___
ACHING	0)___	1)___	2)___	3)___
HEAVY	0)___	1)___	2)___	3)___
TENDER	0)___	1)___	2)___	3)___
SPLITTING	0)___	1)___	2)___	3)___
TIRING/EXHAUSING	0)___	1)___	2)___	3)___
SICKENING	0)___	1)___	2)___	3)___
FEARFUL	0)___	1)___	2)___	3)___
PUNISHING/CRUEL	0)___	1)___	2)___	3)___

Check the word below which best describes the intensity of your pain **NOW**.

- 0 = No Pain ____
- 1 = Mild ____
- 2 = Discomforting ____
- 3 = Distressing ____
- 4 = Horrible ____
- 5 = Excruciating ____

Put a mark through the face below to indicate the intensity of your pain **NOW;**

0	1	2	3	4	5
NO HURT	HURTS LITTLE BIT	HURTS LITTLE MORE	HURTS EVEN MORE	HURTS WHOLE LOT	HURTS WORST

Do you have a family history (Mother, Father, Aunt, Uncle, Brother, Sister) of the following?
Circle all that apply and write a family member: Heart Disease____________________
Diabetes_______________ High Blood Pressure_______________ Stroke_________________
Cancer_________________ Thyroid_________________Anesthesia Problems_______________

Do you exercise regularly?___________________If so, how much?______________________
Do you smoke?____________________If so, how much?______________________________
Do you use any tobacco product?_________________Explain.___________________________
Do you use alcohol?__________________________If so, how much?____________________
Do you use illegal drugs?_______________________Explain.____________________________

Do you have advanced directives (Living Will, Health Care Power of Attorney, Do Not Resuscitate)?
____
Are you an organ donor?____
Do you have cultural, religious or personal value, belief or preference related to care/treatment?____________If so, please explain._____________________________________
____
Have you ever had a visit to the emergency room for overdose or pain?___________________
Have you ever been admitted to the hospital for overdose or pain?________________________
Did that admission require a stay in the ICU?____
Do you have a history of participation in an alcohol or substance abuse treatment program?_______________If so, explain____
Do you have history of physical abuse/domestic violence?_____________________________
Current physical abuse/domestic violence?____
Are there any cultural, religious, emotional barriers to communication or learning?____________
If so, please explain:____
What is your preferred language for discussing your health care? English ________Spanish________
Other____

SOAPP-R QUESTIONAIRE

NAME:____________________ DOB:____________ DATE:____________

Please answer the following 24 questions listed below and evaluate them (0 up to 4) on the scale listed:

0= I never have this feeling **1**= I seldom have this feeling **2**=Sometimes I have this feeling
3=Often I have this feeling **4**= Very often I have this feeling

1. How often do you have mood swings? __________
2. How often have you felt a need for higher doses of medication to treat your pain? __________
3. How often have you felt impatient with your doctors? __________
4. How often have you felt that things are just too overwhelming that you cant handle them? __________
5. How often is there tension in the home? __________
6. How often have you counted pain pills to see how many are remaining? __________
7. How often have you been concerned that people will judge you for taking pain medication? __________
8. How often do you feel bored? __________
9. How often have you taken more pain medication than you were supposed to? __________
10. How often have you felt worried about being left alone? __________
11. How often have you felt a craving for medication? __________
12. How often have others expressed concern over your use of medication? __________
13. How often have any of your close friends had a problem with alcohol or drugs? __________
14. How often have others told you that you had a bad temper? __________
15. How often have you felt consumed by the need to get pain medication? __________
16. How often have you run out of pain medication early? __________
17. How often have others kept you from getting what you deserve? __________
18. How often, in your lifetime, have you had legal problems or been arrested? __________
19. How often have you attended an AA or NA meeting? __________
20. How often have you been in an argument that was so out of control that someone got hurt? __________
21. How often have you been sexually abused? __________
22. How often have others suggested that you have a drug or alcohol problem? __________
23. How often have you had to borrow pain medications from your family or friends? __________
24. How often have you been treated for an alcohol or drug problem? __________

PLEASE ADD UP YOUR SCORE: __________

Revival
PAIN MANAGEMENT

Patient Rights

"Patient" is used with the understanding that a designated representative may be acting on behalf of the patient.

ACCESS TO CARE
The right to impartial access to all available services and medically indicated treatments, regardless of race, creed, sexual orientation, gender identity or expression, national origin, handicapping condition, sources of payment, or lack of ability to pay.

RESPECT AND DIGNITY
The right to considerate, respectful care with recognition of their personal dignity, including announcing oneself when a member of the hospital staff enters a patient room and working to assure visual and auditory privacy for the patient.

PRIVACY AND CONFIDENTIALITY
The right to confidentiality of all records and communications, written or oral, between patients and health care providers; except as authorized by the patient or as may be necessary to promote continuity of care, to facilitate reimbursement on the patient's behalf, or to comply with the law. Additionally, if family/ significant other(s) / designated representative are to be included in the discussions of the patient's condition and care needs, the patient should be asked to designate who he/she wishes present or informed. Patients also have the right to personal privacy.

PERSONAL SAFETY
The right to expect reasonable safety insofar as the hospital practices and environment are concerned.

IDENTITY
The right to know the identity, credentials, licensure of all personnel involved in his or her care.

INFORMATION
The right to be informed of his or her health status, to be involved in the care planning and treatment (this includes pain management), and to be able to request and refuse treatment.

The right to obtain from their physicians, in terms they can be reasonably expected to understand, complete current information concerning their diagnosis, treatment and prognosis. When it is not deemed medically prudent to give such information to the patient, the information will be made available to the appropriate person acting for the patient.

The right to access, upon request, all information contained in their medical record; except when such access is specifically restricted for medical reasons by the attending physician.

COMMUNICATION
The right to receive information in a manner he/she understands with access, when and if reasonably possible, to a language interpreter, to TDD, or to a certified sign language interpreter in order to facilitate communication.

CONSENT
The right to receive from their physicians sufficient information for them to give informed consent prior to the start of any procedure and/or treatment, except for circumstance constituting life-threatening emergencies.

The right to refuse to participate in research projects affecting their care or treatment.

CONSULTATION
The right, at their request and expense, to assistance in obtaining consultation with other physicians.

REFUSAL OF TREATMENT
The right, to the extent permitted by the Patient Self-Determination Act and other laws, to refuse treatment and to be informed of the potential or possible consequences of this action.

ETHICAL ISSUES/CARE OF THE DYING
The right to be involved and actively participate in decisions that affect the extent and type of the care they will receive, including the right to participate in questions of pain management and other decisions affecting care of the dying patient.

TRANSFER
The right to expect, within its capabilities, that NRH will make reasonable response to requests for services. When medically appropriate, a patient may be transferred to another facility only after he/she (or an appropriate person on his/her behalf) has received reasonable information concerning the needs for and alternatives to such a transfer. The institution to which the patient is to be transferred must first have accepted the patient for transfer.

CONTINUITY OF CARE
The right to be notified in advance of their impending discharge, to obtain at their own expense a second medical opinion on the appropriateness of discharge and, upon request, to have a person of the patient's choice notified reasonably in advance of the discharge.

Upon discharge, patients will be informed by their physicians of their continuing health care requirements and the resources available for meeting those requirements.

HOSPITAL CHARGES
The right to examine and receive an explanation or clarification of their bill, regardless of the source of payment.

COMPLAINTS AND CONCERNS
The right to express concerns regarding the quality of care being given, in a non-threatening and constructive atmosphere without fear of compromised care now or in the future. Information on the hospital's mechanism for ensuring this right will be presented to the patient or his/her representative during the admission process.

CULTURAL AND SPIRITUAL BELIEFS
The right to exercise any cultural and spiritual beliefs that are not violations of the law. The care of a patient shall include the psychosocial, spiritual and cultural values that influence the perceptions of illness.

FORMULATE ADVANCED DIRECTIVES
The right under State law to formulate advanced directives. Information regarding advanced directives will be given at the time of admission or registration.

FREE FROM VERBAL OR PHYSICAL ABUSE OR HARASSMENT
The right to be free from abuse. While the patient is under the hospital's care and on its property, the hospital is responsible for ensuring the patient's health and safety and his or her physical, emotional, and psychological well being.

FREE FROM SECLUSION AND RESTRAINT
The right to be free from seclusion, physical restraints, and drugs that are used as a restraint that are not medically necessary or are used as a means of coercion, discipline, convenience, or retaliation by staff.

NOTIFICATION OF ADMISSION
The right to have a family member or representative of his/her choice and his/her personal physician notified promptly of admission to the hospital.

PAIN MANAGEMENT
The right to have pain relieved or controlled.

VISITATION
The right to be informed of their visitation rights, including any clinical restrictions or limitations on visitation. The patient or support person, where appropriate, may consent or deny to receive visitors whom he or she designates, including, but not limited to, a spouse, domestic partner (including same-sex domestic partner), another family member, or a friend, and may withdraw or deny consent at any time. Visitation will not be restricted, limited, or denied based on race, color, national origin, religion, sex, gender identity, sexual orientation, or disability.

Patient Responsibilities

1. To provide, to the best of their knowledge, accurate and complete information about present conditions, past illnesses, hospitalizations, medications and other matters relating to their health.
2. To report to the practitioner responsible for their care, any unexpected changes in their condition.
3. To report whether they clearly comprehend a contemplated course of action and what is expected of them.
4. To inform their physicians of any existing advance directives and for providing a copy of any and all current such documents as near to the time of admission as possible.
5. To follow the treatment plan recommended by the practitioner primarily responsible for their care.
6. To keep appointments and, if they are unable to do so for any reason, notify the responsible practitioner (or the hospital).
7. To assure that the financial obligations of their health care are fulfilled as promptly as possible.
8. To follow hospital rules and regulations in place to support quality patient care and a safe environment.
9. To support mutual consideration and respect by maintaining civil language and conduct in interactions with staff and licensed independent practitioners.
10. To be respectful of the property of other persons and of the hospital.
11. Patients are responsible to:
    - ask their doctor or nurse what to expect regarding pain and pain management,
    - discuss pain relief options with their doctors and nurses,
    - work with their doctor and nurse to develop a pain management plan,
    - ask for pain relief when pain first begins,
    - help their doctor and nurse assess their pain,
    - tell their doctor or nurse if their pain is not relieved, and
    - tell their doctor or nurse about any worries they have about taking pain medication.

PATIENT RIGHTS ACKNOWLEDGEMENT OF RECEIPT

I, ___________________________________, acknowledge that I have received a copy of Revival Pain Management Patient Rights.

Patient Signature: ______________________________Date:________________________

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of June 10, 2002, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a formal, written complaint with our office or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information, by asking to speak to our Privacy Officer or for written inquiries, note "Attention Privacy Officer".

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(202) 619-0257
Toll Free: 1-877-696-6775

Patients Legal Name ____

Date of Birth__________________ Sex ( ) F ( ) M Race:______________ SS#_________________

Marital Status ( ) Single ( ) Married ( ) Divorced ( ) Widowed ( ) Separated

I hereby acknowledge receipt of the NOTICE OF PRIVACY PRACTICES and PATIENTS/PARENTS/GUARDIANS RESPONSIBILTY given to me by Northern Pain Management.

I give permission to Northern Pain Management to file any claims on my behalf to my insurance company for billing purposes. I also give permission to Northern Pain Management to send any medical records requested by my insurance company to process these claims.

I understand that I am responsible for any charges in full at time of visit if I do not have insurance. I am responsible to pay the copay or deductibles at the time of my visit. I further understand that I am responsible for any charges that are NOT a covered service with my insurance plan. I understand that an insurance card presented to Northern Pain Management is not a guarantee of payment.

I give Northern Pain Management permission to send information to my referring physician and referred physician if deemed necessary by my physician.

I give the names listed below permission to discuss my treatment, pick up prescriptions and pick up forms.

____

____

I understand that I may revoke this authorization at any time by presenting a request for revocation in writing to Health Information Department of Northern Pain Management; however, a revocation will not reverse any action already taken in reliance upon this Authorization.
I also understand that the information disclosed pursuant to the authorization may include information concerning patient's mental health, use or treatment concerning drugs and/or alcohol, HIV/AIDS and/or other communicable diseases and/or genetic testing results.

I give Northern Pain Management permission to retrieve my medication history through Sure Scripts E-Prescription Network.

I understand that I have the right to request restrictions concerning the use of any information. Below are those restrictions:

____

Patient or Guardian Signature________________________________Date______________

PATIENT DEMOGRAPHIC INFORMATION

PATIENT NAME: ____________ ____________ ____________ ____________
LAST FIRST MIDDLE MAIDEN

SEX (CIRCLE ONE): M / F BIRTHDATE __/__/__ AGE: _____ SOCIAL SECURITY#____-____-______

ADDTL CATEGORY: ________________

MARITAL STATUS:__SINGLE __ MARRIED __SEPERATED __DIVORCED ___OTHER:________

RACE:__CAUCASIAN(WHITE) __BLACK/AFRICAN AMERICAN __NATIVE AMERICAN(ALASKAN)
___ASIAN __HISPANIC (LATINO) __MIDDLE EASTERN
___PACIFIC ISLANDER __OTHER:______________
___MIXED RACE: ____________________________ __REFUSED TO REPORT OR UNKNOWN

ETHNICITY: ___HISPANIC OR LATINO ___AMERICAN ___OTHER: ____________________
___REFUSE TO REPORT OR UNKNOWN

LANGUAGE PREFERENCE: ___ENGLISH ___SPANISH ___JAPANESE ___GERMAN ___HINDI
___GREEK ___CHINESE ___OTHER:____________________

ADDRESS:______________________________CITY______________STATE________ZIP_______

TELEPHONE: HOME___________________WORK________________CELL__________________

EMAIL ADDRESS: ____

EMPLOYER NAME: _____________________________________ PHONE:____________________

SPOUSE'S NAME: ______________________________________SPOUSE'S SS#____-____-______

EMERGENCY INFORMATION

NAME:____PHONE:___________________
(SOMEONE NOT LIVING AT THE SAME ADDRESS AS YOU)

PRIMARY CARE PHYSICIAN:__________________________________PHONE:___________________

PHARMACY INFORMATION

PERFERRED PHARMACY NAME:______________________________PHONE:____________________

PLEASE SIGN HERE AFTER COMPLETING FORM

SIGNATURE OF PATIENT/GUARDIAN OR POA:_______________________________DATE:__/__/__

PAIN MANAGEMENT

110 Dutchman's Court

Elkin, NC 28621

SUICIDE RISK ASSESSMENT

Patient Name: ______________________________ Date: ____________________

	Ask Questions 1 and 2	YES	NO
1	Have you wished you were dead or wished you could go to sleep and not wake up within the last 30 days?	☐	☐
2	Have you actually had any thought of killing yourself within the last 30 days?	☐	☐

If Yes to 2, ask questions 3, 4, 5, and 6
If No to 2, go directly to question 6

		YES	NO
3	Have you been thinking about how you might do this	☐	☐
4	Have you had these thoughts and had some intention	☐	☐
5	Have you started to work out or worked out details how to kill yourself	☐	☐
6	Have you ever done anything, started to do anything, or prepared to do anything to end your life?	☐	☐
6a	If "YES" - Was it within the past 3 months	☐	☐

COMM QUESTIONAIRE

Patient Name:	**Date:**				
DOB: ______________________________	**Never**	**Seldom**	**Sometimes**	**Often**	**Very Often**
Please answer the questions using the following scale:	**0**	**1**	**2**	**3**	**4**
1. In the past 30 days, how often have you had trouble with thinking clearly or had memory problems?					
2. In the past 30 days, how often do people complain that you are not completing necessary tasks? (i.e., doing things that need to be done, such as going to class, work or appointments)					
3. In the past 30 days, how often have you had to go to someone other than your prescribing physician to get sufficient pain relief from medications? (i.e., another doctor, the Emergency Room, friends, street sources)					
4. In the past 30 days, how often have you taken your medications differently from how they are prescribed?					
5. In the past 30 days, how often have you seriously thought about hurting yourself?					
6. In the past 30 days, how much of your time was spent thinking about opioid medications (having enough, taking them, dosing schedule, etc.)?					
7. In the past 30 days, how often have you been in an argument?					
8. In the past 30 days, how often have you had trouble controlling your anger (e.g., road rage, screaming, etc.)?					
9. In the past 30 days, how often have you needed to take pain medications belonging to someone else?					
10. In the past 30 days, how often have you been worried about how you're handling your medications?					
11. In the past 30 days, how often have others been worried about how you're handling your medications?					
12. In the past 30 days, how often have you had to make an emergency phone call or show up at the clinic without an appointment?					
13. In the past 30 days, how often have you gotten angry with people?					
14. In the past 30 days, how often have you had to take more of your medication than prescribed?					
15. In the past 30 days, how often have you borrowed pain medication from someone else?					
16. In the past 30 days, how often have you used your pain medicine for symptoms other than for pain (e.g., to help you sleep, improve your mood, or relieve stress)?					
17. In the past 30 days, how often have you had to visit the Emergency Room?					
SUM:					