

SOAPP-R

The following are some questions given to patients who are on or being considered for medication for the pain. Please answer each question as honestly as possible. There are no right or wrong answers.

Place an "X" in the column indicating your most accurate response.

Today's Date: _____	Never	Seldom	Sometimes	Often	Very Often
Name: _____					
DOB: _____	0	1	2	3	4
How often do you have mood swings?					
How often have you felt a need for higher doses of medication to treat your pain?					
How often have you felt impatient with your doctors?					
How often have you felt that things are just too overwhelming that you can't handle them?					
How often is there tension in the home?					
How often have you counted pain pills to see how many are remaining?					
How often have you been concerned that people will judge you for taking pain medication?					
How often do you feel bored?					
How often have you taken more pain medication that you were supposed to?					
How often have you worried about being left alone?					
How often have you felt a craving for medication?					
How often have others expressed concern over your use of medication?					
How often have any of your close friends had a problem with alcohol or drugs?					
How often have others told you that you had a bad temper?					

Name:	Never	Seldom	Sometimes	Often	Very Often
DOB:	0	1	2	3	4
How often have you felt consumed by the need to get pain medication?					
How often have you run out of pain					
How often have others kept you from getting what you deserve?					
How often, in your lifetime, have you had legal problems or been arrested?					
How often have you attended an AA or NA meeting?					
How often have you been in an argument that was so out of control that someone got hurt?					
How often have you been sexually abused?					
How often have others suggested that you have a drug or alcohol problem?					
How often have you had to borrow pain					
How often have you been treated for an alcohol or drug problem?					

Please include any additional information you wish about the above answers.

Signature: _____ Date: _____

If you feel that you may have a substance abuse issue, please notify your provider and/or contact one of the following:

STORM, Inc. (Strategic Treatment Options and Recovery Ministries) (405) 503-7442

Veteran Crisis Line (800) 273-8255

Oakwood Springs Rehab (405) 835-3677

Alcoholics Anonymous Intergroup (405) 524-1100