The SpineCare Center

Patient Opioid Risk Assessment Tool

Check Yes or No to the following questions	Yes	No
Do you have a family history of abuse with any of the following substances?		
Alcohol	☐	☐
Illegal drugs/Street drugs	☐	☐
Prescription Drugs	☐	☐
Do you have a personal history of abuse with any of the following substances?		
Alcohol	☐	☐
Illegal drugs/Street drugs	☐	☐
Prescription drugs	☐	☐
Are you between the ages of 16-45 years?	☐	☐
Do you have a history of sexual abuse between the ages of 9-14 years?	☐	☐
Do you have a history of any of the following mental disorders?		
Attention deficit disorder (ADD/ADHD), Obsessive compulsive disorder (OCD), bipolar disorder, schizophrenia	☐	☐
Depression	☐	☐

Questionnaire developed by Lynn R. Webster, MD to assess risk of opioid addiction.

Webster LR, Webster R. Predicting aberrant behaviors in Opioid-treated patients: preliminary validation of the Opioid risk too. Pain Med, 2005; 6 (6): 432

The SpineCare Center

VISIT QUESTIONNAIRE

1. Where did you first hear about us? ☐ Social Media ☐ Online Search ☐ SpineCare Website ☐ Billboard ☐ Magazine/Newspaper ☐ Family/Friend

2. When did your pain first occur? _____ 3. Is this admission/visit due to an accident/injury? ☐ No ☐ Yes
   Date of Accident_____ Location of accident_____ Type of accident _____

4. If this is an injury/accident, are you represented by an attorney? ☐ No ☐ Yes Name_____

5. Who is your primary care physician? _____

6. Location(s) of your pain: _____

7. Have you had any of the following in your legs and/or feet:

	YES	NO	If you answered yes, where was it located?											
Pain	☐	☐	☐ Right Leg	☐ Right Foot	☐ Left Leg	☐ Left Foot	☐ Both Legs	☐ Both Feet						
Weakness	☐	☐	☐ Right Leg	☐ Right Foot	☐ Left Leg	☐ Left Foot	☐ Both Legs	☐ Both Feet						
Numbness	☐	☐	☐ Right Leg	☐ Right Foot	☐ Left Leg	☐ Left Foot	☐ Both Legs	☐ Both Feet						
Tingling	☐	☐	☐ Right Leg	☐ Right Foot	☐ Left Leg	☐ Left Foot	☐ Both Legs	☐ Both Feet						

8. Have you had any of the following in your shoulders, arms and/or hands:

	YES	NO	If you answered yes, where was it located?											
Pain	☐	☐	☐ Right Shoulder	☐ Right Arm	☐ Right Hand	☐ Left Shoulder	☐ Left Arm	☐ Left Hand						
			☐ Both Shoulders	☐ Both Arms	☐ Both Hands									
Weakness	☐	☐	☐ Right Shoulder	☐ Right Arm	☐ Right Hand	☐ Left Shoulder	☐ Left Arm	☐ Left Hand						
			☐ Both Shoulders	☐ Both Arms	☐ Both Hands									
Numbness	☐	☐	☐ Right Shoulder	☐ Right Arm	☐ Right Hand	☐ Left Shoulder	☐ Left Arm	☐ Left Hand						
			☐ Both Shoulders	☐ Both Arms	☐ Both Hands									
Tingling	☐	☐	☐ Right Shoulder	☐ Right Arm	☐ Right Hand	☐ Left Shoulder	☐ Left Arm	☐ Left Hand						
			☐ Both Shoulders	☐ Both Arms	☐ Both Hands									

9. Have you had any of the following:

	YES	NO		YES	NO
Loss of bowel control	☐	☐	Rash	☐	☐
Loss of bladder control	☐	☐			

10. Mark any of the following that describe your pain or symptoms:

☐ mild	☐ occasional	☐ crushing	☐ occurring at rest	☐ stabbing	☐ intermittent
☐ moderate	☐ aching	☐ dull	☐ pressure	☐ stinging	☐ cramping
☐ severe	☐ activity related	☐ fullness	☐ sharp	☐ throbbing	☐ occurring at night
☐ constant	☐ burning	☐ heaviness	☐ shooting	☐ tightening	☐ squeezing

☐ muscle spasms ***Please document location of muscle spasms** _____

11. Please mark any of the following tests or studies you have had done for the problem that you are here for today:

☐ no work ☐ CT myelogram ☐ Lab work
☐ plain films ☐ MRI ☐ MRA Where were they performed? _____
☐ CT scan ☐ EMG-NCV ☐ Bone Scan

12. Have you tried any of the following treatments for the problem that you are here for today:

	YES	Did it help?		Yes	Did it help?
nothing tried	☐	YES ☐	Over the Counter pain meds	☐	YES ☐
rest	☐	YES ☐	NSAIDs (such as Ibuprofen, Aleve, Advil, Etc.)	☐	YES ☐
ice	☐	YES ☐	narcotic pain meds	☐	YES ☐
heat	☐	YES ☐	chiropractic therapy	☐	YES ☐
acupuncture	☐	YES ☐	physical therapy	☐	YES ☐
Muscle relaxants	☐	YES ☐	When? _____		

13. Did you get any relief for any length of time after your last injection or nerve block? Yes ☐ No ☐
If yes, what percent better? _____

14. Do you take a blood thinner? ☐ No ☐ Yes Name of Blood Thinner _____

15. **Who is driving you home?** _____ **You must leave a contact phone #:** _____
Will this person be ☐ **available within 10 minutes from The SpineCare Center or**
☐ **waiting in the waiting room?**

16. **Rate your pain by checking the number or words that best describes your pain:**

At its ***WORST*** in the last month or since here last
No pain ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Pain as bad as you can imagine

At its ***LEAST*** in the last month or since here last
No pain ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Pain as bad as you can imagine

TODAY?
No pain ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Pain as bad as you can imagine

17. Check the number or words that best describe how much pain interferes with your life.
No interference ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Unable to do usual activities

18. Check when your pain is worse: ☐ Morning ☐ Afternoon ☐ Evening ☐ Night or ☐ No typical pattern

19. Sleep: Average number of hours per night: _____ Sleep quality ☐ Good ☐ Fair ☐ Poor

Do you currently have any of the following symptoms or problems with:

General:	YES	NO	If Yes, please explain below:
fever	☐	☐	
chills	☐	☐	
fatigue	☐	☐	
weight gain	☐	☐	
weight loss	☐	☐	
HEENT:			
vision problems	☐	☐	
hearing problems	☐	☐	
speech problems	☐	☐	
Skin:			
open wounds	☐	☐	
rash	☐	☐	
lesions	☐	☐	
Cardiac:			
chest pain	☐	☐	
Pulmonary:			
cough	☐	☐	
wheezing	☐	☐	
shortness of breath	☐	☐	
GI:			
nausea	☐	☐	
vomiting	☐	☐	
diarrhea	☐	☐	
loss of bowel control	☐	☐	
GU:			
difficulty urinating dysuria	☐	☐	
blood in urine (hematuria)	☐	☐	
urinary frequency	☐	☐	
urinary urgency	☐	☐	
loss of bladder control	☐	☐	

Musculoskeletal:	YES	NO	
back pain	☐	☐	
joint pain	☐	☐	
muscle weakness	☐	☐	
leg pain	☐	☐	
arthritis	☐	☐	
Endo:			
diabetes	☐	☐	
thyroid disease	☐	☐	
Psych:			
nervousness	☐	☐	
anxiety	☐	☐	
mood swings	☐	☐	
depression	☐	☐	
Heme:			
anemia	☐	☐	
Immunological:			
HIV/AIDS	☐	☐	
Leukemia	☐	☐	
Neuro:			
seizures	☐	☐	
tremors	☐	☐	
syncope	☐	☐	
memory loss	☐	☐	
loss of balance	☐	☐	
headache	☐	☐	
blurred vision	☐	☐	

Date/Time _____ Patient's Signature _____

Date/Time _____ Nurse's Signature _____

DCH Health System®

Visit Questionnaire