

Pain Management Clinic  
SOAPP@R

The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers. Please fill in the circle under the number that applies to you.

	NEVER	SELDOM	SOME TIMES	OFTEN	VERY OFTEN
	0	1	2	3	4
1. How often do you have mood swings?	0	0	0	0	0
2. How often have you felt a need for higher doses of medication to treat your pain?	0	0	0	0	0
3. How often have you felt impatient with your doctors?	0	0	0	0	0
4. How often have you felt that things are just too overwhelming that you can't handle them?	0	0	0	0	0
5. How often is there tension in the home?	0	0	0	0	0
6. How often have you counted pain pills to see how many are remaining?	0	0	0	0	0
7. How often have you been concerned that people will judge you for taking pain medication?	0	0	0	0	0
8. How often do you feel bored?	0	0	0	0	0
9. How often have you taken more pain medication than you were supposed to?	0	0	0	0	0
10. How often have you worried about being left alone?	0	0	0	0	0
11. How often have you felt a craving for medication?	0	0	0	0	0
12. How often have others expressed concern over your use of medication?	0	0	0	0	0

Date Completed: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

PT.
MR.#/P.M.
DR.

