Date: ____/______/________

SUBOXONE FOLLOW UP QUESTIONNAIRE

Name (last) ___________________________ (first) ________________ DOB _________ Age __________ Sex: Male Female

CURRENT SYMPTOMS Please mark the location(s) of your pain with an "X" and show where it goes with an arrow.
If whole areas are painful, shade in the painful area. Circle the words which best describe you pain.

	Front		Back	
sharp		shooting		burning
throbbing		electric-like		skin sensitivity to light touch, cold
cutting		pins and needles		abnormal swelling, hair/nail growth
dull, aching		weakness		abnormal sweating
pressure		numbness		abnormal skin color changes
muscle pain				abnormal skin temperature
cramping	right left		left right	limited movement

Do you have this pain: ☐ constantly (90-100% of the time), ☐ frequently (75%), ☐ intermittently (50%), ☐ occasionally (25%)

Pain Intensity: Circle your pain intensity with "0" representing no pain and "10" the most severe pain imaginable														
Current	None	0	1	2	3	4	5	6	7	8	9	10	Severe
Least pain score the last 7 days	None	0	1	2	3	4	5	6	7	8	9	10	Severe
Worst pain score the last 7 days	None	0	1	2	3	4	5	6	7	8	9	10	Severe
With medications	None	0	1	2	3	4	5	6	7	8	9	10	Severe
Without medications	None	0	1	2	3	4	5	6	7	8	9	10	Severe

Please list ALL medications from all providers and mark refills you'll need before your next visit

Medication	Dose	How many at a time	How many times a day	Benefits/ side effects	Last intake?	Refill needed?

Prior injections or procedures

DATE	NAME OF PROCEDURE	HOW MUCH PAIN RELIEF?	FOR HOW LONG?	SIDE EFFECTS
1.		%		
2.		%		

Comments/Goals for this appointment: ____

Have there been any significant changes in your health or pain control since your last visit? ☐ No ☐ Yes, if **yes** explain: ______________

____

Were you able to increase your activities? ☐ Yes ☐ No Were you able to decrease your intake of pain medication? ☐ Yes☐ No

Activity Scale (Circle) Work full time/ Work part time/ Able to leave home without help/ Require help to leave home/ House confined

I sleep in ________hour increments, for a total of_______ hours in a 24 hour period. Do you feel rested? ☐ Yes ☐ No

What makes your pain worse? ____

What makes your pain better? ____

Daily activities: ____

Weekly activities: ____

What do you do to improve your pain control? ____

What are your goals with treatment? ____________________________________ Are we helping you meet your goals? ☐ Yes ☐ No

Is constipation a problem? ☐ Yes ☐ No Do you feel depressed? ☐ Yes ☐ No

Do you use alcohol? ☐ No ☐ Yes If yes, list frequency/ amount: ____________________________

Do you use marijuana or any other recreational drugs? ☐ No ☐ Yes ____________________________

When did you take your last dose of opioid ?____________________________

Are you pregnant? ☐ N/A ☐ No ☐ Not sure ☐ Yes ____________________________