Healthy Living Primary Care

Screener and Opioid Assessment for Patients with Pain (SOAPP)

Name: _____ Date: _____

The following are some questions given to all patients at the Pain Management Center who are on or being considered for opioids for their pain. Please answer each question as honestly as possible. This information is for our records and will remain confidential. Your answers alone will not determine your treatment. Thank you.

Please answer the questions below using the following scale:

0 = Never, 1 = Seldom, 2 = Sometimes, 3 = Often, 4 = Very Often

	0	1	2	3	4
1. How often do you have mood swings?					
2. How often do you smoke a cigarette within an hour after you wake up?					
3. How often have any of your family members, including parents and grandparents, had a problem with alcohol or drugs?					
4. How often have any of your close friends had a problem with alcohol or drugs?					
5. How often have others suggested that you have a drug or alcohol problem?					
6. How often have you attended an AA or NA meeting?					
7. How often have you taken medication other than the way that it was prescribed?					
8. How often have you been treated for an alcohol or drug problem?					
9. How often have your medications been lost or stolen?					
10. How often have others expressed concern over your use of medication?					
11. How often have you felt a craving for medication?					
12. How often have you been asked to give a urine screen for substance abuse?					
13. How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years?					
14. How often, in your lifetime, have you had legal problems or been arrested?					

Total: _____

STOP-BANG

	Yes	No
Snoring? Do you **snore loudly** (loud enough to be heard through closed doors, or your bed partner elbows you for snoring at night)?		
Tired? Do you often feel **tired, fatigued, or sleepy** during the daytime (such as falling asleep during driving)?		
Observed? Has anyone **observed** you **stop breathing** or **choking/gasping** during your sleep?		
Pressure? Do you have or are being treated for **high blood pressure**?		
Body mass index more than 35 kg/m^2?		
Age older than 50 years old?		
Neck size large? (measured around Adam's apple) For male, is your shirt collar 17 inches or larger? For female, is your shirt collar 16 inches or larger?		
Gender = Male?		

Total: _____

OPIOID RISK TOOL (ORT)

			Mark each box that applies	Item score if FEMALE	Item score if MALE
1	Family history of substance abuse	Alcohol	☐	1	3
		Illegal drugs	☐	2	3
		Prescription drugs	☐	4	4
2	Personal history of substance abuse	Alcohol	☐	3	3
		Illegal drugs	☐	4	4
		Prescription drugs	☐	5	5
3	Age (mark box if 16–45)		☐	1	1
4	History of preadolescent sexual abuse		☐	3	0
5	Psychological disease	Attention deficit disorder	☐	2	2
		Obsessive compulsive disorder	☐	2	2
		Bipolar	☐	2	2
		Schizophrenia	☐	2	2
		Depression	☐	1	1
			TOTAL	_____	_____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐