

Name: _____ DOB: _____ Date: _____

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. Use ✓ to indicate your answer.

	NEVER	SELDOM	SOMETIMES	OFTEN	VERY OFTEN
	0	1	2	3	4
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2					
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FOR PROVIDER USE ONLY:

Score:		Provider Signature:	
Comments:			