Pain Medication Assessment

Patient Name **Date**

Questions	Yes	No	Notes
I have taken my pain medication in larger amounts or over a longer period of time than intended			
I have wanted to and/or been unable to cut down or control my use of pain medication			
I spend a great deal of time in activities necessary to obtain my pain medications, use pain medication, or recover from the effects of my pain medication			
I experience cravings or a strong desire to use my pain medication			
My use of pain medication has affected by ability to fulfill major role obligations at work, school, or home			
I have continued using pain medications in spite of having persistent or recurrent social or interpersonal problems caused or made worse by the effects of my pain medication			
I have given up or reduced my work or recreational activities because of my pain medication			
I have used pain medication at times when I drive, use large equipment, or in other situations that may be physically dangerous			
I continue to use pain medication even though I know I have persistent or recurrent physical or psychological problem that is likely to be caused by or made worse by my pain medication			
I have to increase my pain medication dose in order to feel the same relief Or I do not have the same amount of pain control with the current dose of medication as I did before			
I have experienced withdrawal symptoms when I forget or run out of my pain medication or Sometimes I take other medications or substances to relieve or avoid withdrawal symptoms			