Screening & Assessment Form

_____ _____ _____

Name DOB Date

This form is given to all patients wishing to establish care at Phoenician Pain wishing to be seen by one of our Pain Management physicians. Answer every question on this form with complete honesty, to the best of your ability. Clinical treatment will not be based upon these answers alone. All your answers will be held confidentially by our practice.

Please answer the following questions based on the numerical value below:

0 = Never 1 = Rarely 2 = Sometimes 3 = Frequently 4 = Very Often

Do you experience mood swings?	**0 1 2 3 4**
Do you smoke a cigarette shortly after waking up?	**0 1 2 3 4**
How often have any of your family members had any issues of addiction or abuse to any alcohol or drugs?	**0 1 2 3 4**
How often have any of your friends had any issues of addiction or abuse to any alcohol or drugs?	**0 1 2 3 4**
Do others mention that you may have an issue with alcohol or drug abuse?	**0 1 2 3 4**
Do you attend any Alcoholic Anonymous or other addiction support meetings?	**0 1 2 3 4**
How often do you see a Psychologist or Psychiatrist?	**0 1 2 3 4**
Have you taken any medication other than the way it was prescribed?	**0 1 2 3 4**
Have you ever been treated for an alcohol or drug abuse problem?	**0 1 2 3 4**
Have you ever had your medication(s) go missing, be lost or stolen?	**0 1 2 3 4**
Have others ever told you they are concerned with your medication(s)?	**0 1 2 3 4**
Do you ever have a craving for your medication(s)?	**0 1 2 3 4**
Have you been asked to give a urine or blood screen for substance abuse?	**0 1 2 3 4**
How often have you used illicit substances (marijuana, cocaine, etc.) in the past five years?	**0 1 2 3 4**
Have you ever had any legal problems or been arrested?	**0 1 2 3 4**