NORTH TEXAS SPINE & PAIN

1001 SARA SWAMY DR. SUITE 220
SHERMAN TX,75090
PHONE: 903-892-1999 FAX: 903-892-6999

SOAPP SCORE

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 follow

0 = Never 1 = seldom 2= sometimes 3= often 4 = very often

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

PLEASE INCLUDE ANY ADDITIONAL INFORMATION YOU WISH ABOUT THE ABOVE ANSWERS, THANK YOU