

SF-12 Health Survey

This survey asks for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities. Answer each question by choosing just one answer. If you are unsure how to answer a question, please give the best answer you can.

1. In general, would you say your health is:

₁ Excellent ₂ Very good ₃ Good ₄ Fair ₅ Poor

The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

	YES, limited a lot	YES, limited a little	NO, not limited at all
2. Moderate activities such as moving a table, pushing a vacuum cleaner, bowling, or playing golf.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃
3. Climbing several flights of stairs.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

	YES	NO
4. Accomplished less than you would like.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
5. Were limited in the kind of work or other activities.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

	YES	NO
6. Accomplished less than you would like.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂
7. Did work or activities less carefully than usual.	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂

8. During the past 4 weeks, how much did pain interfere with your normal work (including work outside the home and housework)?

₁ Not at all ₂ A little bit ₃ Moderately ₄ Quite a bit ₅ Extremely

These questions are about how you have been feeling during the past 4 weeks.

For each question, please give the one answer that comes closest to the way you have been feeling.

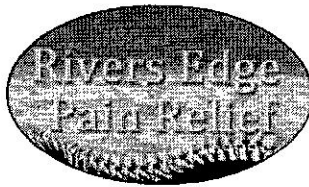
How much of the time during the past 4 weeks...

	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
9. Have you felt calm & peaceful?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
10. Did you have a lot of energy?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆
11. Have you felt down-hearted and blue?	<input type="checkbox"/> ₁	<input type="checkbox"/> ₂	<input type="checkbox"/> ₃	<input type="checkbox"/> ₄	<input type="checkbox"/> ₅	<input type="checkbox"/> ₆

12. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?

₁ All of the time ₂ Most of the time ₃ Some of the time ₄ A little of the time ₅ None of the time

Patient name:	Date:	PCS:	MCS:
Visit type (circle one)			
Preop	6 week	3 month	6 month
			12 month
			24 month
			Other:



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Name: _____

Date: _____

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Please answer each question as honestly as possible. Keep in mind that we are only asking about the **past 30 days**. There are no right or wrong answers. If you are unsure about how to answer the question, please give the best answer you can.

Please answer the questions using the following scale.	N E V E R	S E L D O M	S O M E T I M E S	O F T E N	V E R Y O F T E N
	0	1	2	3	4
1. In the past 30 days, how often have you had trouble with thinking clearly or had memory problems?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. In the past 30 days, how often do people complain that you are not completing necessary tasks? (i.e., doing things that need to be done, such as going to class, work or appointments)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. In the past 30 days, how often have you had to go to someone other than your prescribing physician to get sufficient pain relief from medications? (i.e., another doctor, the Emergency Room, friends, street sources)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. In the past 30 days, how often have you taken your medications differently from how they are prescribed?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. In the past 30 days, how often have you seriously thought about hurting yourself?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. In the past 30 days, how much of your time was spent thinking about opioid medications (having enough, taking them, dosing schedule, etc.)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>





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	0	1	2	3	4
7. In the past 30 days, how often have you been in an argument?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. In the past 30 days, how often have you had trouble controlling your anger (i.e., road rage, screaming, etc.)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. In the past 30 days, how often have you needed to take pain medications belonging to someone else?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. In the past 30 days, how often have you been worried about how you're handling your medications?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. In the past 30 days, how often have others been worried about how you're handling your medications?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. In the past 30 days, how often have you had to make an emergency phone call or show up at the clinic without an appointment?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13. In the past 30 days, how often have you gotten angry with people?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. In the past 30 days, how often have you had to take more of your medication than prescribed?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15. In the past 30 days, how often have you borrowed pain medication from someone else?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16. In the past 30 days, how often have you used your pain medication for symptoms other than for pain (i.e., to help you sleep, improve your mood, or relieve stress)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17. In the past 30 days, how often have you had to visit the Emergency Room?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



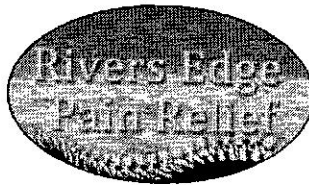
YOUR SCORE: _____

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BEHAVIOR

	Often	Weekly	Rarely
I feel tense, anxious, or have nervous indigestion.	2	1	0
People at work/ home make me feel tense.	2	1	0
I eat/ drink/ smoke in response to tension.	2	1	0
I have tension or migraine headaches, or pain in neck or shoulders, or insomnia.	2	1	0
I can't turn off my thoughts at night or on weekends long enough to feel relaxed and refreshed the next day.	2	1	0
I find it difficult to concentrate on what I'm doing because I'm worrying about other things.	2	1	0
I take tranquilizers or other drugs to relax.	2	1	0
Once I find time, it is hard for me to relax.		Yes- 1	No- 0
My workday is made up of many deadlines.		Yes- 1	No- 0

MAXIMUM TOTAL SCORE = 18



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YOUR SCORE: _____

Name: _____

Date: _____

SOAPP Version 1.0-14Q

The following are some questions given to all patients at Rivers Edge Pain Relief 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

How often do you have mood swings?	0	1	2	3	4
How often do you smoke a cigarette within an hour After you wake up?	0	1	2	3	4
How often have any of your family members including parents or grandparents, had a problem with alcohol or drugs?	0	1	2	3	4
How often have any of your close friends had a problem with alcohol or drugs?	0	1	2	3	4
How often have others suggested that you have a drug or alcohol problem?	0	1	2	3	4
How often have you attended AA or NA meetings?	0	1	2	3	4
How often have you taken medication other than the way it was prescribed?	0	1	2	3	4
How often have you been treated for an alcohol or drug problem?	0	1	2	3	4
How often have your medications been lost or stolen?	0	1	2	3	4
How often have others expressed concern over your use of medication?	0	1	2	3	4
How often have you felt a craving for medication?	0	1	2	3	4
How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years?	0	1	2	3	4
How often, in your lifetime, have you had legal problems or been arrested?	0	1	2	3	4