

ACTIVATE: Patients Managing Pain  
6-month follow-up telephone interview

**ENTERED BY RESEARCH STAFF BEFORE INTERVIEW BEGINS:**

**PPN:** \_ \_ \_ \_ \_

Thank you again for agreeing to be part of the ACTIVATE Study. Please answer questions as honestly as you can. Your answers are confidential. You can refuse to answer any questions or stop the questionnaire at any time. We will be asking a variety of questions with various different time periods. Please refer to the time period specific to each question. Some of the questions may seem similar; please be assured every question is important.

## DEMOGRAPHICS

1. **D1GENDER** – Gender [PRE-POPULATE FROM BASELINE]  
1 ☐ Male  
2 ☐ Female  
3 ☐ Other (e.g., Transgender, Intersex)  
Specify: \_\_\_\_\_
2. **D1MASTAT** – Marital status  
What is your current marital status?  
1 ☐ Married  
2 ☐ Living with Intimate Partner  
3 ☐ Widowed  
4 ☐ Divorced or separated  
5 ☐ Single, never married
3. **D1EMSTAT** - Employment Status  
What best describes your current employment status?  
1 ☐ Employed full-time  
2 ☐ Employed part-time  
3 ☐ Unemployed  
4 ☐ Retired  
5 ☐ Fulltime Homemaker →SKIP TO D1EDUC  
6 ☐ Student (Not employed) → SKIP TO D1EDUC  
7 ☐ Disabled
4. **D1EDUC** – Education  
What is the highest level of education you have completed?  
1 ☐ 12 years or less: \_ \_  
2 ☐ High School diploma or GED  
3 ☐ A.A., A.S., other vocational program  
4 ☐ B.A., B.S.  
5 ☐ M.A., M.S.  
6 ☐ Ph.D., M.D., J.D.

5. **D1LIVSIT** – Current living situation  
What best describes your current living situation?  
*Check the box that best applies*
- 1 ☐ House or apartment (you rent or own)  
2 ☐ House or apartment of friend or relative  
3 ☐ Halfway house or residence in therapeutic community  
4 ☐ Single room occupancy (SRO), hotel or motel  
5 ☐ Homeless (streets, shelter, car, no stable arrangement)  
6 ☐ Institution (jail, hospital)  
7 ☐ Other (Specify): \_\_\_\_\_
6. **D1LIVSUP** – Current living support  
Who do you currently live with?
- 1 ☐ Alone  
2 ☐ With friend(s) or relative(s)  
7 ☐ Other (Specify): \_\_\_\_\_
7. **D1INCOME**  
What is your yearly household income after taxes?  
*Check the box that applies*
- 1 ☐ Less than \$10,000                      7 ☐ \$60,001 - \$70,000  
2 ☐ \$10,001 - \$20,000                      8 ☐ \$70,001 - \$80,000  
3 ☐ \$20,001 - \$30,000                      9 ☐ \$80,001 - \$90,000  
4 ☐ \$30,001 - \$40,000                      10 ☐ \$90,001 - \$100,000  
5 ☐ \$40,001 - \$50,000                      11 ☐ over \$100,000  
6 ☐ \$50,001 - \$60,000                      97 ☐ Rather not say

## PATIENT ACTIVATION (PAM)

Now we will ask you some questions about how you feel about your involvement in your own healthcare.

8. Below are some statements that people sometimes make when they talk about their health. Please indicate how much you agree or disagree with each statement as it applies to you personally by checking your answer.

| Question                                                                                                                | Disagree Strongly          | Disagree                   | Agree                      | Strongly Agree             |
|-------------------------------------------------------------------------------------------------------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| <b>A. PIHLTHRESP</b><br>When all is said and done, I am the person who is responsible for taking care of my health      | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| <b>B. PIHTLTH ACT</b><br>Taking an active role in my own health care is the most important thing that affects my health | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| <b>C. PIHLTH CON</b><br>I am confident I can help prevent or reduce problems associated with my health                  | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| <b>D. PIKNOWRX</b><br>I know what each of my prescribed medications do                                                  | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| <b>E. PIGODOC</b>                                                                                                       | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |

|                                                                                                                                         |                            |                            |                            |                            |
|-----------------------------------------------------------------------------------------------------------------------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| I am confident that I can tell whether I need to go to the doctor or whether I can take care of a health problem myself                 |                            |                            |                            |                            |
| <b>F. PITELLDOC</b><br>I am confident that I can tell a doctor concerns I have even when he or she does not ask                         | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| <b>G. PICONFTX</b><br>I am confident that I can follow through on medical treatments I may need to do at home                           | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| <b>H. PIUNDER</b><br>I understand my health problems and what causes them                                                               | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| <b>I. PITXAVAIL</b><br>I know what treatments are available for my health problems                                                      | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| <b>J. PIMAIN</b><br>I have been able to maintain (keep up with) lifestyle changes, like eating right or exercising                      | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| <b>K. PIPREV</b><br>I know how to prevent problems with my health                                                                       | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| <b>L. PISOLU</b><br>I am confident I can figure out solutions when new problems arise with my health                                    | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| <b>M. P1LIFE</b><br>I am confident that I can maintain lifestyle changes, like eating right and exercising, even during times of stress | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |

## SATISFACTION WITH CARE

Now I will ask you some questions about your satisfaction with your health care.

### 9. T1STSOVCARE

How would you rate your satisfaction with your overall health care on a scale of "1" to "10," where "1" is the worst possible care and "10" is the best possible care?

1      2      3      4      5      6      7      8      9      10  
 |-----|-----|-----|-----|-----|-----|-----|-----|-----|

Worst Possible Care

Best Possible Care

Answer: \_\_\_\_\_

### 10. T1STSPCP

How would you rate your satisfaction with your primary care physician on a scale of "1" to "10," where "1" is the worst possible care and "10" is the best possible care?

1      2      3      4      5      6      7      8      9      10  
 |-----|-----|-----|-----|-----|-----|-----|-----|-----|

Worst Possible Care

Best Possible Care

Answer: \_\_\_\_\_

**11. T1STSPAINMG**

How would you rate your satisfaction with your pain management care on a scale of "1" to "10," where "1" is the worst possible care and "10" is the best possible care?

|          |          |          |          |          |          |          |          |          |           |
|----------|----------|----------|----------|----------|----------|----------|----------|----------|-----------|
| <b>1</b> | <b>2</b> | <b>3</b> | <b>4</b> | <b>5</b> | <b>6</b> | <b>7</b> | <b>8</b> | <b>9</b> | <b>10</b> |
| -----    | -----    | -----    | -----    | -----    | -----    | -----    | -----    | -----    | -----     |

Worst Possible Care

Best Possible Care

Answer: \_\_\_\_\_

## HEALTH CARE UTILIZATION

The next series of questions ask about your health care use. Please respond to the questions to the best of your ability.

**12. H1KPMEMB**

Are you still a Kaiser member?

- 1 ☐ Yes **IF YES, SKIP TO H1KPCOUNS**  
 2 ☐ No  
 97 ☐ Refused/Don't know

**13. H1NOKPRSN**

Why did you leave Kaiser Health Plan?

- 1 ☐ Moved out of area  
 2 ☐ Switched to another health plan  
 3 ☐ Lost job/lost coverage  
 4 ☐ Other \_\_\_\_\_  
 97 ☐ Refused/Don't know

**14. H1KPCOUNS**

In the *past 6 months*, did you receive advice or counseling from a Kaiser doctor, nurse, health educator, or other Kaiser health care professional about the following? (This does not include appointments or group sessions with the study research staff or clinician.): *Check all that apply*

- 1 ☐ Pain management  
 2 ☐ Your diet (what you eat)  
 3 ☐ Losing weight  
 4 ☐ Getting more exercise  
 5 ☐ Quitting smoking  
 6 ☐ Stress or emotional problems (like depression)  
 7 ☐ Health screening tests recommended for you  
 8 ☐ No advice or counseling

**15. H1KPPAINPGM**

In the *past 6 months*, did you participate in a pain management program at Kaiser? (This does not include appointments or group sessions with the study research staff or clinician.)

- 1 ☐ Yes, attended  
 2 ☐ Was referred but never attended  
 3 ☐ No

**16. H1COMP**

Do you have access to a personal computer?

- 1 ☐ Yes, at home  
2 ☐ Yes, at other location  
3 ☐ No

**17. H1INTER**

Do you have access to the Internet?

- 1 ☐ Yes, at home  
2 ☐ Yes, at other location  
3 ☐ No

**18. H1KPORG**

Have you accessed KP.org in the past 6 months? (This does not include appointments or group sessions with the study research staff or clinician.)

- 1 ☐ Yes  
2 ☐ No → **SKIP TO H1HLTHEDKP**  
97 ☐ Don't Know/Refused

**19. H1WAYS KP**

In what ways have you used KP.org in the past 6 months? (This does not include appointments or group sessions with the study research staff or clinician.)

*Check all that apply*

- 1 ☐ Emailed my doctor or received an email from my doctor  
2 ☐ Checked my lab results or immunization history  
3 ☐ Scheduled or cancelled a medical appointment  
4 ☐ Ordered a prescription refill  
5 ☐ Reviewed information from a past visit  
6 ☐ Used KP.org's Health and Wellness Resources (healthy lifestyle programs, wellness coaching, audio podcasts, recipe blogs, tools/calculators, videos).

**20. H1HLTHEDKP**

Have you attended a Kaiser Health Education Class in the past 6 months? (This does not include group sessions with the study clinician.)

- 1 ☐ Yes  
2 ☐ No  
97 ☐ Don't Know/Refused

The next several questions ask about health services you may have received OUTSIDE of Kaiser Permanente.

**21. H1NONKPS**

Excluding dental care, prescription refills or optometry/eyeglasses, did you receive any medical care **not paid for by** Kaiser Permanente during the past 6 months?

- 1 ☐ Yes  
2 ☐ No → **SKIP TO C1TXPAINFR**

**22. H1ERD1**

During the past 6 months, how many days were you a patient in a non-Kaiser **emergency room** that Kaiser did not pay for?

\_\_\_ \_\_\_ \_\_\_ Days

23. **H1HOSPD1**  
During the past 6 months, how many days were you a patient **overnight (excluding for labor and delivery) in a non-Kaiser hospital** that Kaiser did not pay for?  
\_\_\_ \_\_\_ \_\_\_ Days
24. **H1SAINV1**  
During the past 6 months, how many episodes of treatment did you have in an outpatient treatment program (NOT including AA or any other self-help group) for **alcohol or drug problems** outside of Kaiser that Kaiser did not pay for?  
\_\_\_ \_\_\_ \_\_\_ Times
25. **H1PAINTXNKP**  
During the past 6 months, how many episodes of treatment in a **pain management** program outside of Kaiser did you have that Kaiser did not pay for?  
\_\_\_ \_\_\_ \_\_\_ Times
26. **H1SYMDV1**  
During the past 6 months, how many times did you see a provider (e.g., psychiatrist, psychologist, social worker) for **mental health or emotional problems** as an outpatient outside of Kaiser that Kaiser did not pay for?  
\_\_\_ \_\_\_ \_\_\_ Times
27. **H1PCV1**  
During the past 6 months, how many times did you see a **primary care provider** (nurse or physician) as an **outpatient** outside of Kaiser that Kaiser did not pay for?  
\_\_\_ \_\_\_ \_\_\_ Times
28. **H1OTHPV1**  
During the past 6 months, how many times did you see a **medical provider in other clinics (e.g., dermatology or allergies)** as an outpatient outside of Kaiser that Kaiser did not pay for?  
\_\_\_ \_\_\_ \_\_\_ Times

## CHRONIC PAIN EXPECTATIONS

We are interested in your expectations for relief of your pain. Please indicate how much you agree or disagree with each statement.

| Question                                                                           | Disagree Strongly          | Disagree                   | Agree                      | Strongly Agree             |
|------------------------------------------------------------------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| 29. C1TXPAINFR<br>I expect that treatment will make me pain free.                  | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| 30. C1ACCPNTX<br>I accept that I will have some pain with even the best treatment. | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |

The next questions are about your use of prescription opioid pain medicines.

**31. C1OPIRXMED**

Are you **currently** taking prescription opioid pain medication? Some examples of opiate pain medicines are: Codeine, Darvocet, Darvon, Fentanyl, Hydrocodone, Methadone, Morphine, Norco, Oxycodone, Oxycontin, Percocet, Percodan, Propoxyphene, and Vicodin)

1 ☐ Yes

2 ☐ No      SKIP TO C1STPOPIRX

**32. C1PAINMED**

What prescription opioid pain medications have you taken in the past two weeks?

*Check all that apply*    USE DROP DOWN LIST FROM BASELINE

**33. C1PMEDDAYS**

In the past 2 weeks, about how many days did you take prescription opioid pain medicines?

\_\_\_\_\_ Days ENTER "0" IF DIDN'T TAKE OPIOIDS IN PAST 2 WEEKS

97 ☐ Refused/Don't know

**34. C1TMPMED**

In the past 2 weeks, about how many times per day did you usually take prescription opioid pain medicine on the days you used these medicines?

\_\_\_\_\_ Times per day ENTER "0" IF DIDN'T TAKE OPIOIDS IN PAST 2 WEEKS

97 ☐ Refused/Don't know

**35. C1PMEDRX**

Do you always take your prescription opioid pain medication as prescribed?

1 ☐ Yes      SKIP TO C1PMADSE

2 ☐ No

**36. C1NOPMEDRSN**

Please describe why you sometimes don't take your prescription opioid medication as prescribed.

Please check all that apply:

1 ☐ Side Effects

2 ☐ Poor pain control (take more than prescribed because amount prescribed doesn't help)

3 ☐ Do not need it

4 ☐ Concern about overuse

5 ☐ Pain is bad and need more than prescribed

7 ☐ Other (Specify): \_\_\_\_\_

**37. C1PMADSE**

Considering all of the possible side effects of opiate medicines you may have experienced in the past month, (such as nausea, constipation, grogginess), how bothersome were these side effects?

1 ☐ Not at all bothersome

2 ☐ A little bothersome

3 ☐ Moderately bothersome

4 ☐ Very bothersome

5 ☐ Extremely bothersome

97 ☐ Refused/Don't know

Which two side effects bother you the most?

**37A. C1SIDEFMOST1**

Feeling groggy or sluggish  
Feeling unstable or dizzy  
Feeling confused or disoriented  
Constipation  
Nausea/vomiting  
Nightmares  
Itchiness  
Difficulty urinating or difficulty with urinary retention  
Less interest in sex or other sexual difficulties  
Other: specify \_\_\_\_\_

**37B C1SIDEFMOST2**

Feeling groggy or sluggish  
Feeling unstable or dizzy  
Feeling confused or disoriented  
Constipation  
Nausea/vomiting  
Nightmares  
Itchiness  
Difficulty urinating or difficulty with urinary retention  
Less interest in sex or other sexual difficulties  
Other: specify \_\_\_\_\_

**38. C1HELPOP**

Over the past month, how helpful have you found opiate pain medicines in relieving your pain.

- 1 ☐ Not at all helpful  
2 ☐ A little helpful  
3 ☐ Moderately helpful  
4 ☐ Very helpful  
5 ☐ Extremely helpful  
97 ☐ Refused/Don't know

**39. C1IMPCUTMED**

How important is it for you to decrease your opioid use?

- 1 ☐ Not at all important  
2 ☐ A little important  
3 ☐ Moderately important  
4 ☐ Very important  
5 ☐ Extremely important  
97 ☐ Refused/Don't know

**40. C1CONFCUTMED**

How confident are you that you can decrease your opioid use?

- 1 ☐ Not at all confident  
2 ☐ A little confident  
3 ☐ Moderately confident  
4 ☐ Very confident  
5 ☐ Extremely confident

97 ☐ Refused/Don't know

**41. C1LTMGOAL**

What is your **current** long-term goal for using prescription opioids for pain management?

- 1 ☐ Stay the same
- 2 ☐ Increase use
- 3 ☐ Decrease use
- 4 ☐ Stop use

**42. C1IMPGOAL**

How important is it for you to reach your goal?

- 1 ☐ Not at all important
- 2 ☐ A little important
- 3 ☐ Moderately important
- 4 ☐ Very important
- 5 ☐ Extremely important
- 97 ☐ Refused/Don't know

**43. C1DOCSTOP**

Has your doctor talked to you about stopping or tapering your opioids in the last 6 months?

- 1 ☐ Yes
- 2 ☐ No

**44. C1CUTOPIUSE**

Are you currently in the process of tapering (gradually decreasing) your opioid use?

- 1 ☐ Yes
- 2 ☐ No → skip to **C1GETOPINKP**

**45. C1DECPVDOPICUT**

Do you feel like a partner with your doctor in this decision to taper your opioid use?

- 1 ☐ Yes
- 2 ☐ No

**NEXT THREE QUESTIONS ARE ONLY FOR THOSE NO LONGER TAKING OPIOIDS**

**46. C1STPOPIRX**

How long ago did you stop taking opioids?

\_\_\_\_\_ months

**47. C1NOOPIRXRS**

Why did you stop taking opioids?

- 1 ☐ No longer needed
- 2 ☐ Too expensive
- 3 ☐ Side effects
- 4 ☐ Found other ways to decrease pain
- 5 ☐ Doctor strongly encouraged

- 6 ☐ Family encouraged  
 7 ☐ Other. Specify: \_\_\_\_\_

**48. C1DECPVDOPICUTNOOP**

Did you feel like a partner with your doctor in this decision to stop your opioid use?

- 1 ☐ Yes  
 2 ☐ No

NEXT 7 QUESTIONS ARE ASKED OF EVERYONE

**49. C1GETOPINKP**

Have you tried to obtain opioids from other sources in the last 6 months as result of your KP doctor wanting to decrease your opioid use?

- 1 ☐ Yes  
 2 ☐ No

**50. C1CHGDOCOPICUT**

Have you switched doctors in the last 6 months, as result of your KP doctor wanting to decrease your opioid use?

- 1 ☐ Yes  
 2 ☐ No

**51. C1LFKPOPICUT**

Have you thought about leaving Kaiser in the last 6 months, as result of your KP doctor wanting to decrease your opioid use?

- 1 ☐ Yes  
 2 ☐ No  
 3 ☐ NA – not a KP member in the last 6 months

Six months ago, you indicated your long tem goal for opioid use was to **[INSERT ANSWER FROM COLTMGOAL]**.

**52. C1OPIGOAL**

To what extent do you feel you have met your goals for opioid use in the past 6 months?

- 1 ☐ To a great extent → **SKIP TO C1MDREF**  
 2 ☐ Somewhat → **SKIP TO C1MDREF**  
 3 ☐ Very little  
 4 ☐ Not at all

**53. C1NOSUCCSS**

Why do you think you were not as successful as you would have liked?

- 1 ☐ Didn't have the support from doctor/health care system  
 2 ☐ Didn't have the support of family/friends  
 3 ☐ Pain is too bad  
 4 ☐ Unable to find alternative ways to reduce pain  
 5 ☐ Lost health insurance  
 6 ☐ Other: specify \_\_\_\_\_

**54. C1MDREF**

How do you currently manage your pain? *Check all that apply*

- 1 ☐ Opioid medication prescribed by a doctor  
 2 ☐ Non-opioid medication prescribed by a doctor  
 3 ☐ Over the counter medication (like Tylenol)  
 2 ☐ Complementary/Alternative Medicine (i.e., acupuncture, herbs) Specify: \_\_\_\_\_

- 3 ☐ Meditation, relaxation, or mindfulness practice  
 4 ☐ Pain classes or therapy (group or individual)  
 5 ☐ Massage or other bodywork  
 6 ☐ Exercise, stretching or physical therapy  
 7 ☐ Nothing  
 8 ☐ Other Specify: \_\_\_\_\_  
 97 ☐ Refused/Don't know

**55. C1RXS**

During the last 6 months, how many of your own opiate prescriptions did you get filled at **NON-Kaiser** pharmacies (including through **NON-Kaiser** web sites)?

\_\_\_\_\_ Prescriptions

**[IF NO LONGER ON OPIOIDS, SKIP the SOAPP and the COMM]**

**SCREENER AND OPIOID ASSESSMENT FOR PATIENTS WITH PAIN (SOAPP-5)**

**56.** Now a few general questions about your mood and drug use.

| Question                                                                                                                    | Never                      | Seldom                     | Sometimes                  | Often                      | Very Often                 |
|-----------------------------------------------------------------------------------------------------------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| <b>A. S1MOODSWG</b><br>How often do you have mood swings?                                                                   | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| <b>B. S1SMKWP</b><br>How often do you smoke a cigarette within an hour after you wake up?                                   | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| <b>C. S1MEDNFRX</b><br>How often have you taken medication other than the way that it was prescribed?                       | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| <b>D. S1USEDRG</b><br>How often have you used illegal drugs (for example, marijuana, cocaine, etc.) in the past five years? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| <b>E. S1LEGPRB</b><br>How often, in your lifetime, have you had legal problems or been arrested?                            | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |

## CURRENT OPIOID MISUSE (COMM)

**57.** 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.

| Question                                                                                                                                                                                                                                       | Never                      | Seldom                     | Sometimes                  | Often                      | Very Often                 |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| <b>A. C1TRBMEMB</b><br>In the past 30 days, how often have you had trouble with thinking clearly or had memory problems?                                                                                                                       | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| <b>B. C1UNDNTASK</b><br>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)                                 | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| <b>C. C1GTNRXMED</b><br>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) | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| <b>D. C1TKNMEDURXWY</b><br>In the past 30 days, how often have you taken your medications differently from how they are prescribed?                                                                                                            | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| <b>E. C1THGTHURT</b><br>In the past 30 days, how often have you seriously thought about hurting yourself?                                                                                                                                      | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| <b>F. C1TMTHKOPI</b><br>In the past 30 days, how much of your time was spent thinking about opioid medications (having enough, taking them, dosing schedule, etc.)?                                                                            | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| <b>G. C1ARGUE</b><br>In the past 30 days, how often have you been in an argument?                                                                                                                                                              | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| <b>H. C1TRBCNTLANGER</b><br>In the past 30 days, how often have you had trouble controlling your anger (e.g., road rage, screaming, etc.)?                                                                                                     | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| <b>I. C1TKMEDSMO</b><br>In the past 30 days, how often have you needed to take pain medications belonging to someone else?                                                                                                                     | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| <b>J. C1WRRHDLMED</b><br>In the past 30 days, how often have you been worried about how you're handling your medications?                                                                                                                      | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| <b>K. C1OTHWRRHDLMED</b><br>In the past 30 days, how often have others been worried about how you're handling your medications?                                                                                                                | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| <b>L. C1ERCALL</b><br>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?                                                                                             | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| <b>M. C1ANGRYOTH</b><br>In the past 30 days, how often have you gotten angry with people?                                                                                                                                                      | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| <b>N. C1MOREMED</b><br>In the past 30 days, how often have you had to take more of your medication than prescribed?                                                                                                                            | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |

|                                                                                                                                                                                             |                            |                            |                            |                            |                            |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| <b>O. C1BRRWPMED</b><br>In the past 30 days, how often have you borrowed pain medication from someone else?                                                                                 | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| <b>P. C1PMEDOTHRSN</b><br>In the past 30 days, how often have you used your pain medicine for symptoms other than for pain (e.g., to help you sleep, improve your mood, or relieve stress)? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| <b>Q. C1VSTER</b><br>In the past 30 days, how often have you had to visit the Emergency Room?                                                                                               | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |

## CHRONIC PAIN COPING INVENTORY - 42

The next series of questions ask you about non-medication self-management strategies for reducing chronic pain. *Self-management includes regular relaxation, physical activity, talking with others, and/or making time for social activities.*

**58.** During *the past week*, how many days did you use each of the following at least once in the day to cope with your pain? (Note: You may have used some of these coping strategies on days that you did not have pain or to prevent or minimize pain in the future. Please indicate the number of days you used each strategy for pain, whether or not you were experiencing pain at the time).

| Question                                                                                    | Number of Days                                                                                                                                                                                                          |
|---------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>A. P1RELAX</b><br>Imagined a calming or distracting image to help me relax               | <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 |
| <b>B. P1IGNPAIN</b><br>Ignored the pain                                                     | <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 |
| <b>C. P1REST</b><br>I took a rest                                                           | <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 |
| <b>D. P1SUPTFRD</b><br>I got support from a friend                                          | <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 |
| <b>E. P1ASKOTHHLP</b><br>Asked someone to do something for me                               | <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 |
| <b>F. P1WORSE</b><br>Reminded myself that things could be worse                             | <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 |
| <b>G. P1AVOID</b><br>Avoided using part of my body (e.g. hand, arm, leg)                    | <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 |
| <b>H. P1RELXMSL</b><br>Focused on relaxing my muscles                                       | <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 |
| <b>I. P1STRTCH</b><br>Sat on the floor ,stretched ,and held the stretch at least 10 seconds | <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 |
| <b>J. P1BETTER</b><br>Told myself things would get better                                   | <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 |
| <b>K. P1SPTFAM</b><br>I got support from a family member                                    | <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 |
| <b>L. P1RESTMUCH</b><br>I rested as much as I could                                         | <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 |
| <b>M. P1TALK</b><br>I talked to someone close to me                                         | <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 |
| <b>N. P1CALLFRD</b><br>Called a friend on the phone to help me feel better                  | <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 |
| <b>O. P1THTGOOD</b><br>Thought about all the good things I have                             | <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 |
| <b>P. P1HLPTASK</b>                                                                         |                                                                                                                                                                                                                         |

|                                                                                                                   |                                                                                                                                                                                                                         |
|-------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Asked for help with a chore or task                                                                               | <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 |
| <b>Q. P1PAINBET</b><br>Told myself my pain would get better                                                       | <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 |
| <b>R. P1NOINTFACT</b><br>I didn't let the pain interfere with my activities                                       | <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 |
| <b>S. P1AERBEXE</b><br>Engaged in aerobic exercise (exercise that made my heart beat faster) for at least 15 min. | <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 |
| <b>T. P1LMTWLK</b><br>Limited my walking because of pain                                                          | <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 |
| <b>U. P1NPAPAIN</b><br>Just didn't pay attention to the pain                                                      | <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 |
| <b>V. P1WLKLMP</b><br>Walked with a limp to decrease the pain                                                     | <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 |
| <b>W. P1MEDRELX</b><br>Meditated to relax                                                                         | <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 |
| <b>X. P1LAYBACK</b><br>Lay on my back, stretched, and held the stretch at least 10 seconds                        | <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 |
| <b>Y. P1HLDPST</b><br>Held part of my body (e.g. arm) in a special position                                       | <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 |
| <b>Z. P1HLPLIFT</b><br>Asked for help in carrying, lifting or pushing something                                   | <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 |
| <b>AA. P1EXEIMPV</b><br>Exercised to improve my overall physical condition for at least 5 minutes                 | <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 |
| <b>BB. P1TLKSUPT</b><br>Talked to a friend or family member for support                                           | <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 |
| <b>CC. P1RMDOTHWRS</b><br>Reminded myself that there are people who are worse off than I am                       | <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 |
| <b>DD. P1LMTSTNDTM</b><br>Limited my standing time                                                                | <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 |
| <b>EE. P1LAYDWN</b><br>Lay down on a bed                                                                          | <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 |
| <b>FF. P1AVDPHYACT</b><br>Avoided some physical activities (lifting, pushing, carrying)                           | <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 |
| <b>GG. P1SHRELAX</b><br>Used self-hypnosis to relax                                                               | <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 |
| <b>HH. P1KPTGO</b><br>I just kept going                                                                           | <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 |
| <b>II. P1STRCHMSCL</b><br>Stretched the muscles where I hurt and held the stretch for at least 10 seconds         | <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 |
| <b>JJ. P1AVDACT</b><br>Avoided activity                                                                           | <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 |
| <b>KK. P1RMREST</b><br>Went into a room by myself to rest                                                         | <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 |
| <b>LL. P1DPBRTHRLX</b><br>Used deep, slow breathing to relax                                                      | <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 |
| <b>MM. P1EXEMSCLBK</b><br>Exercised to strengthen the muscles in my back for at least 1 minute                    | <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 |
| <b>NN. P1ASKGETSMTH</b><br>Asked someone to get me something (e.g. medicine, food, drink)                         | <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 |
| <b>OO. P1PAINOAFECT</b><br>Did not let the pain affect what I was doing                                           | <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 |
| <b>PP. P1LAYDWSOFA</b><br>Lay down on a sofa                                                                      | <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 |

## FACIT-Sp-Ex (version 4)

59. Now I am going to ask you a few questions about your spirituality. Please indicate how much you agree with each statement by marking one box per row.

| Statement                                                                 | Not at all                 | A little bit               | Somewhat                   | Quite a bit                | Very much                  |
|---------------------------------------------------------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| <b>A. F1STRGFAITH</b><br>I find strength in my faith or spiritual beliefs | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| <b>B. F1HIGHPW</b><br>I feel connected to a higher power (or God)         | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |

## PAIN SELF EFFICACY QUESTIONNAIRE (PSEQ)

60. Please rate how confident you are that you can do the following things at present, despite the pain. To indicate your answer circle one of the numbers on the scale under each item, where 0 = not at all confident and 6 = completely confident. Remember, we are not asking whether or not you have been doing these things, but rather how confident you are that you can do them at present, despite the pain.

| Question                                                                                                                      | Not at all Confident       |                            |                            |                            |                            |                            | Completely Confident       |
|-------------------------------------------------------------------------------------------------------------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| <b>A. P1ENJOY</b><br>I can enjoy things, despite the pain.                                                                    | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> | 6 <input type="checkbox"/> |
| <b>B. P1DOCHORE</b><br>I can do most of the household chores (e.g. tidying-up, washing dishes, etc.), despite the pain.       | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> | 6 <input type="checkbox"/> |
| <b>C. P1SOCFRND</b><br>I can socialize with my friends or family members as often as I used to do, despite the pain.          | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> | 6 <input type="checkbox"/> |
| <b>D. P1COPEPAIN</b><br>I can cope with my pain in most situations.                                                           | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> | 6 <input type="checkbox"/> |
| <b>E. P1DOWORK</b><br>I can do some form of work, despite the pain. ("work" includes housework, paid and unpaid work).        | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> | 6 <input type="checkbox"/> |
| <b>F. P1DOMTHG</b><br>I can still do many of the things I enjoy doing, such as hobbies or leisure activity, despite the pain. | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> | 6 <input type="checkbox"/> |
| <b>G. P1COPEWOMED</b><br>I can cope with my pain without medication.                                                          | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> | 6 <input type="checkbox"/> |
| <b>H. P1ACCMPGOAL</b><br>I can still accomplish most of my goals in life, despite the pain.                                   | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> | 6 <input type="checkbox"/> |
| <b>I. P1LIVENMLF</b><br>I can live a normal lifestyle, despite the pain.                                                      | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> | 6 <input type="checkbox"/> |
| <b>J. P1MOREACTV</b><br>I can gradually become more active, despite the pain.                                                 | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> | 6 <input type="checkbox"/> |

## PATIENT-REPORTED OUTCOME MEASUREMENT INFORMATION SYSTEM 29-ITEM HEALTH PROFILE (PROMIS-29) AND SEXUAL FUNCTIONING

**61.** The next sets of questions ask you about your activity level, emotional well-being, and pain level. Please respond to each question or statement by marking one box per row.

| <b>Physical Function</b>                                                              | <b>Without any difficulty</b> | <b>With a little difficulty</b> | <b>With some difficulty</b> | <b>With much difficulty</b> | <b>Unable to do</b>        |
|---------------------------------------------------------------------------------------|-------------------------------|---------------------------------|-----------------------------|-----------------------------|----------------------------|
| <b>A. P1CHORE</b><br>Are you able to do chores such as vacuuming or yard work?        | 1 <input type="checkbox"/>    | 2 <input type="checkbox"/>      | 3 <input type="checkbox"/>  | 4 <input type="checkbox"/>  | 5 <input type="checkbox"/> |
| <b>B. P1STAIRS</b><br>Are you able to go up and down stairs at a normal pace?         | 1 <input type="checkbox"/>    | 2 <input type="checkbox"/>      | 3 <input type="checkbox"/>  | 4 <input type="checkbox"/>  | 5 <input type="checkbox"/> |
| <b>C. P1WALK</b><br>Are you able to go for a walk of at least 15 minutes?             | 1 <input type="checkbox"/>    | 2 <input type="checkbox"/>      | 3 <input type="checkbox"/>  | 4 <input type="checkbox"/>  | 5 <input type="checkbox"/> |
| <b>D. P1ERRANDS</b><br>Are you able to run errands and shop?                          | 1 <input type="checkbox"/>    | 2 <input type="checkbox"/>      | 3 <input type="checkbox"/>  | 4 <input type="checkbox"/>  | 5 <input type="checkbox"/> |
| <b>Anxiety</b>                                                                        | <b>Never</b>                  | <b>Rarely</b>                   | <b>Sometimes</b>            | <b>Often</b>                | <b>Always</b>              |
| In the past 7 days....                                                                |                               |                                 |                             |                             |                            |
| <b>E. P1FEAR</b><br>I felt fearful.....                                               | 1 <input type="checkbox"/>    | 2 <input type="checkbox"/>      | 3 <input type="checkbox"/>  | 4 <input type="checkbox"/>  | 5 <input type="checkbox"/> |
| <b>F. P1FOCUS</b><br>I found it hard to focus on anything other than my anxiety...    | 1 <input type="checkbox"/>    | 2 <input type="checkbox"/>      | 3 <input type="checkbox"/>  | 4 <input type="checkbox"/>  | 5 <input type="checkbox"/> |
| <b>G. P1WORRY</b><br>My worries overwhelmed me.....                                   | 1 <input type="checkbox"/>    | 2 <input type="checkbox"/>      | 3 <input type="checkbox"/>  | 4 <input type="checkbox"/>  | 5 <input type="checkbox"/> |
| <b>H. P1UNEASY</b><br>I felt uneasy.....                                              | 1 <input type="checkbox"/>    | 2 <input type="checkbox"/>      | 3 <input type="checkbox"/>  | 4 <input type="checkbox"/>  | 5 <input type="checkbox"/> |
| <b>Depression</b>                                                                     | <b>Never</b>                  | <b>Rarely</b>                   | <b>Sometimes</b>            | <b>Often</b>                | <b>Always</b>              |
| In the past 7 days....                                                                |                               |                                 |                             |                             |                            |
| <b>I. P1WRTHLS</b><br>I felt worthless.....                                           | 1 <input type="checkbox"/>    | 2 <input type="checkbox"/>      | 3 <input type="checkbox"/>  | 4 <input type="checkbox"/>  | 5 <input type="checkbox"/> |
| <b>J. P1HLPLS</b><br>I felt helpless.....                                             | 1 <input type="checkbox"/>    | 2 <input type="checkbox"/>      | 3 <input type="checkbox"/>  | 4 <input type="checkbox"/>  | 5 <input type="checkbox"/> |
| <b>K. P1DEPRESS</b><br>I felt depressed.....                                          | 1 <input type="checkbox"/>    | 2 <input type="checkbox"/>      | 3 <input type="checkbox"/>  | 4 <input type="checkbox"/>  | 5 <input type="checkbox"/> |
| <b>L. P1HOPELS</b><br>I felt hopeless.....                                            | 1 <input type="checkbox"/>    | 2 <input type="checkbox"/>      | 3 <input type="checkbox"/>  | 4 <input type="checkbox"/>  | 5 <input type="checkbox"/> |
| <b>Fatigue</b>                                                                        | <b>Not at all</b>             | <b>A little bit</b>             | <b>Somewhat</b>             | <b>Quite a bit</b>          | <b>Very much</b>           |
| During the past 7 days....                                                            |                               |                                 |                             |                             |                            |
| <b>M. P1FLTFTG</b><br>I felt fatigued.....                                            | 1 <input type="checkbox"/>    | 2 <input type="checkbox"/>      | 3 <input type="checkbox"/>  | 4 <input type="checkbox"/>  | 5 <input type="checkbox"/> |
| <b>N. P1TRBTHK</b><br>I have trouble <u>starting</u> thinking because I am tired..... | 1 <input type="checkbox"/>    | 2 <input type="checkbox"/>      | 3 <input type="checkbox"/>  | 4 <input type="checkbox"/>  | 5 <input type="checkbox"/> |
| In the past 7 days....                                                                |                               |                                 |                             |                             |                            |
| <b>O. P1RUNDOWN</b><br>How run down did you feel on average?                          | 1 <input type="checkbox"/>    | 2 <input type="checkbox"/>      | 3 <input type="checkbox"/>  | 4 <input type="checkbox"/>  | 5 <input type="checkbox"/> |
| <b>P. P1HOWFTG</b><br>How fatigued were you on average?                               | 1 <input type="checkbox"/>    | 2 <input type="checkbox"/>      | 3 <input type="checkbox"/>  | 4 <input type="checkbox"/>  | 5 <input type="checkbox"/> |

| <b>Sleep Disturbance</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | <b>Very poor</b>           | <b>Poor</b>                | <b>Fair</b>                | <b>Good</b>                | <b>Very good</b>           |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| In the past 7 days....                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                            |                            |                            |                            |                            |
| <b>Q. P1SLPQLT</b><br>My sleep quality was.....                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| In the past 7 days....                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | <b>Not at all</b>          | <b>A little bit</b>        | <b>Somewhat</b>            | <b>Quite a bit</b>         | <b>Very much</b>           |
| <b>R. P1SLPRFRSH</b><br>My sleep was refreshing.....                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| <b>S. P1PRBSLP</b><br>I had a problem with my sleep.....                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| <b>T. P1DFTSLP</b><br>I had difficulty falling asleep....                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| <b>Satisfaction with Social Role</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | <b>Not at all</b>          | <b>A little bit</b>        | <b>Somewhat</b>            | <b>Quite a bit</b>         | <b>Very much</b>           |
| In the past 7 days....                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                            |                            |                            |                            |                            |
| <b>U. P1SATWRK</b><br>I am satisfied with how much work I can do (include work at home)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| <b>V. P1SATWKABLT</b><br>I am satisfied with my ability to work (include work at home)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| <b>W. P1SATRESPNS</b><br>I am satisfied with my ability to do regular personal and household responsibilities                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| <b>X. P1SATPERFM</b><br>I am satisfied with my ability to perform my daily routines                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| <b>Pain Interference</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            | <b>Not at all</b>          | <b>A little bit</b>        | <b>Somewhat</b>            | <b>Quite a bit</b>         | <b>Very much</b>           |
| In the past 7 days....                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                            |                            |                            |                            |                            |
| <b>Y. P1PAINACT</b><br>How much did pain interfere with your day to day activities?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| <b>Z. P1PAINWRK</b><br>How much did pain interfere with work around the home?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| <b>AA. P1PAINSOC</b><br>How much did pain interfere with your ability to participate in social activities?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| <b>BB. P1PAINCHORE</b><br>How much did pain interfere with your household chores?                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| <b>Pain Intensity</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                            |                            |                            |                            |                            |
| In the past 7 days....                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                            |                            |                            |                            |                            |
| <b>CC. P1PAINRT</b><br>How would you rate your pain on average on a scale of 1 to 10?<br><div style="display: flex; justify-content: space-between; align-items: center;"> <span>1</span> <span>2</span> <span>3</span> <span>4</span> <span>5</span> <span>6</span> <span>7</span> <span>8</span> <span>9</span> <span>10</span> </div> <div style="display: flex; justify-content: space-between; align-items: center; margin-top: 5px;"> <div style="border-top: 1px dashed black; width: 100%;"></div> </div> <div style="display: flex; justify-content: space-between; align-items: center; margin-top: 5px;"> <span>No Pain</span> <span>Worst Imaginable Pain</span> </div> |                            |                            |                            |                            |                            |
| Answer: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                            |                            |                            |                            |                            |

## PROMIS

Next are just a few questions about your sex life.

**62. P1SEXACT**

In the past **30 days**... Have you had any type of sexual activity with another person (including your partner)?

- 1 ☐ Yes  
2 ☐ No

**63. P1STSSEXLF**

In the past **30 days**... How satisfied have you been with your sex life?

- 1 ☐ Not at all  
2 ☐ A little bit  
3 ☐ Somewhat  
4 ☐ Quite a bit  
5 ☐ Very

**SOCIAL SUPPORT****64. S1PSNHELP**

How many people will help you with practical things when you need it, like giving you rides, helping with baby-sitting, a quick loan, and so forth?

\_\_\_\_\_ number of people

**65. S1FAMCNTCT**

About how many family members (including spouse) and friends, lovers or partners would you say you regularly have contact with? (By regularly, we mean you see them or talk on the phone with them at least twice a month on average.)

\_\_\_\_\_ number of people

**66. S1PSNTALK**

How many people do you have in your life to talk to when you worry about personal problems, such as family or work?

\_\_\_\_\_ number of people

**PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)**

**67.** Now I am going to ask you about your mood in the past two weeks.

Over the last 2 weeks, how often have you been bothered by any of the following problems?

|                                                                   | Not at all                 | Several days               | More than half the days    | Nearly every day           |
|-------------------------------------------------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| <b>A. P1LILPLS</b><br>Little interest or pleasure in doing things | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> |
| <b>B. P1DEPRES</b><br>Feeling down, depressed, or hopeless        | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> |
| <b>C. P1TRBSLP</b>                                                | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> |

|                                                                                                                                                                                              |                            |                            |                            |                            |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| Trouble falling or staying asleep, or sleeping too much                                                                                                                                      |                            |                            |                            |                            |
| <b>D. P1TIRED</b><br>Feeling tired or having little energy                                                                                                                                   | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> |
| <b>E. P1APPET</b><br>Poor appetite or overeating                                                                                                                                             | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> |
| <b>F. P1FELBAD</b><br>Feeling bad about yourself — or that you are a failure or have let yourself or your family down                                                                        | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> |
| <b>G. P1CONCEN</b><br>Trouble concentrating on things, such as reading the newspaper or watching television                                                                                  | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> |
| <b>H. P1SLOW</b><br>Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> |
| <b>I. P1HURT</b><br>Thoughts that you would be better off dead or of hurting yourself in some way                                                                                            | 0 <input type="checkbox"/> | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> |

|                                                                                                                                                                                                                                                     |                                                              |                                                         |                                                     |                                                          |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------------------|-----------------------------------------------------|----------------------------------------------------------|
| <b>J. P1DIFWOR</b><br><b>IF P1LILPLS THRU P1HURT=0 THEN SKIP:</b><br>If you checked off <u>any</u> problems, how <u>difficult</u> have these problems made it for you to do your work, take care of things at home, or get along with other people? | Not<br>difficult<br>at all<br><br>1 <input type="checkbox"/> | Somewhat<br>difficult<br><br>2 <input type="checkbox"/> | Very<br>difficult<br><br>3 <input type="checkbox"/> | Extremely<br>difficult<br><br>4 <input type="checkbox"/> |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------|---------------------------------------------------------|-----------------------------------------------------|----------------------------------------------------------|

## PROMIS GLOBAL HEALTH (QoL)

The following are questions about your general quality of life.

68. Please respond to each item by marking one box per row.

| Statement                                                                                                                                                                                                                                                  | Poor                       | Fair                       | Good                       | Very good                  | Excellent                  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| A. <b>Q1HELTH</b><br>In general, would you say your health is:                                                                                                                                                                                             | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| B. <b>Q1QLTLIFE</b><br>In general, would you say your quality of life is:                                                                                                                                                                                  | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| C. <b>Q1RTPHLTH</b><br>In general, how would you rate your physical health?                                                                                                                                                                                | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| D. <b>Q1RTMHLTH</b><br>In general, how would you rate your mental health, including your mood and your ability to think?                                                                                                                                   | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| E. <b>Q1RTSTSSOC</b><br>In general, how would you rate your satisfaction with your social activities and relationships?                                                                                                                                    | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| F. <b>Q1RTSOCACT</b><br>In general, please rate how well you carry out your usual social activities and roles. (This includes activities at home, at work and in your community, and responsibilities as a parent, child, spouse, employee, friend, etc.). | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
|                                                                                                                                                                                                                                                            | Not at all                 | A little                   | Moderately                 | Mostly                     | Completely                 |
| G. <b>Q1PHYACT</b><br>To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?                                                                                  | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| <b>IN THE PAST 7 DAYS....</b>                                                                                                                                                                                                                              | Always                     | Often                      | Sometimes                  | Rarely                     | Never                      |
| H. <b>Q1EMPRB</b><br>How often have you been bothered by emotional problems such as feeling anxious, depressed or irritable?                                                                                                                               | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| I. <b>Q1RTFTG</b><br>How would you rate your fatigue on average?                                                                                                                                                                                           | Very severe                | Severe                     | Moderate                   | Mild                       | None                       |

|  | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
|--|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|

## SUBSTANCE USE QUESTION NIDA-MODIFIED ASSIST

Next we are going to ask you some questions about substance use.  
As a reminder, your answers are completely confidential.

69. In the past 6 months, which of the following substances have you used?

| Question                                                                                                                                               | Yes                        | No                         |
|--------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|----------------------------|
| <b>A. A1EVEEMAR</b><br><b>Cannabis</b> (marijuana, pot, grass, hash, etc.)                                                                             | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| <b>B. A1EVECOC</b><br><b>Cocaine</b> (coke, crack, etc.)                                                                                               | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| <b>C. A1EVERXSTI</b><br><b>Prescription stimulants</b> (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)                                      | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| <b>D. A1EVEMET</b><br><b>Methamphetamine</b> (speed, crystal meth, ice, etc.)                                                                          | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| <b>E. A1EVEINH</b><br><b>Inhalants</b> (nitrous oxide, glue, gas, paint thinner, etc.)                                                                 | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| <b>F. A1EVESED</b><br><b>Sedatives or sleeping pills</b> (Valium, Serepax, Ativan, Xanax, Librium, Rohypnol, GHB, etc.)                                | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| <b>G. A1EVEHAL</b><br><b>Hallucinogens</b> (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)                                                       | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| <b>H. A1EVEHER</b><br><b>Street opioids</b> (heroin, opium, etc.)                                                                                      | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| <b>I. A1EVERXOPI</b><br><b>Prescription opioids</b> (fentanyl, oxycodone [OxyContin, Percocet], hydrocodone [Vicodin], methadone, buprenorphine, etc.) | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| <b>J. A1EVEOTH</b><br><b>Other – Specify:</b>                                                                                                          | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> |

IF A1EVEEMAR THRU A1EVEOTH = 1 THEN GO TO A1USEDRG3M

IF A1EVEEMAR THRU A1EVEOTH = 2 THEN SKIP TO S1SMK100

70. Ask the following questions for each drug mentioned above:

| Question                                                                                                                                                 | Never                      | Once or Twice              | Monthly                    | Weekly                     | Daily or Almost Daily      |
|----------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| <b>A. A1USEDRG3M</b><br><i>In the past 3 months, how often have you used (insert name of drug)?</i><br><b>IF A1USEDRG3M = 1 THEN SKIP TO A1FRDCRNDRG</b> | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| <b>B. A1DESRUSEDRG</b><br><i>In the past 3 months, how often have you had a strong desire or urge to use (insert name of drug)?</i>                      | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |

|                                                                                                                                                             |                            |                            |                                          |                            |                                      |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------|----------------------------|------------------------------------------|----------------------------|--------------------------------------|
| <b>C. A1OFTUSEDRG</b><br>In the past 3 months, how often has your use of (insert name of drug) led to health, social, legal or financial problems?          | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/>               | 4 <input type="checkbox"/> | 5 <input type="checkbox"/>           |
| <b>D. A1FAILDO</b><br>In the past 3 months, how often have you failed to do what was normally expected of you because of your use of (insert name of drug)? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/>               | 4 <input type="checkbox"/> | 5 <input type="checkbox"/>           |
| Ask Questions “E”& “F” for all substances <i>used in the last 6 months</i> :                                                                                | <b>NO</b>                  |                            | <b>YES, but not in the last 3 months</b> |                            | <b>YES, in the past three months</b> |
| <b>E. A1FRDCRNDRG</b><br>Has a friend or relative or anyone else ever expressed concern about your use of (insert name of drug)?                            | 1 <input type="checkbox"/> |                            | 2 <input type="checkbox"/>               |                            | 3 <input type="checkbox"/>           |
| <b>F. A1FAILCUTDRG</b><br>Have you ever tried and failed to control, cut down, or stop using (insert name of drug)?                                         | 1 <input type="checkbox"/> |                            | 2 <input type="checkbox"/>               |                            | 3 <input type="checkbox"/>           |

**IF A1EVEMAR =1, AND A1USEDRG3M\_MAR = 2,3,4,5, THEN A1MAR30D ...**

**(IF A1EVEMAR = 2 OR A1USEDRG3M\_MAR = 1 THEN SKIP TO S1SMK100)**

**71. A1MAR30D**

Did you use marijuana in past 30 days for medical purposes, as prescribed by a health care provider?

- 1 ☐ Yes  
2 ☐ No  
3 ☐ Sometimes for medical reasons, sometimes not  
97 ☐ Don't Know/Refused

**71A. A1MARRSN**

Please indicate all the health or medical reasons for which you used marijuana in the past 30 days.

- 1 ☐ Pain  
2 ☐ Appetite  
3 ☐ Anxiety  
4 ☐ Depression  
5 ☐ Sleep  
7 ☐ Other (Specify): \_\_\_\_\_  
97 ☐ Don't Know/Refused

## CIGARETTES/SMOKING

Now we are going to ask you a few questions about smoking.

72. **S1SMK100**

Have you smoked at least 100 cigarettes (5 packs or more) in your lifetime?

1 ☐ Yes

2 ☐ No →SKIP TO S1ECIG30D

73. **S1SMKAVGDY**

On average, how many cigarettes per day do you usually smoke (or did you usually smoke when you did smoke)?

\_\_\_ # of Cigarettes

74. **S1DYSMK30D**

In the past 30 days, on how many days did you smoke at least one cigarette?

\_\_\_ # Days ENTER "0" IF YOU DO NOT CURRENTLY SMOKE

75. **S1ECIG30D**

In the past 30 days, on how many days did you use an E-cigarette/E-Hookah/Vape pen?

\_\_\_ # of Days ENTER "0" IF DO NOT CURRENTLY USE E-CIG

## ALCOHOL USE

1 drink is equal to a 12 ounce can of beer, a 5 ounce glass of wine, a 1.5 ounce shot of liquor, or an 8-9 ounce malt liquor

**IF D1GENDER ≠ 1 OR (D1GENDER = 1 AND D1AGE > 65) THEN SKIP TO T1ALCF4**

76. **T1ALCM5**

How many times in the past three months have you had 5+ drinks containing alcohol in a day?

\_\_\_ # of Days

**IF D1GENDER = 1 AND D1AGE ≤ 65 THEN SKIP TO T1DRINKS**

77. **T1ALCF4**

How many times in the past three months have you had 4+ drinks containing alcohol in a day?

\_\_\_ # of Days

78. **T1DRINKS**

On a typical drinking day, how many drinks do you have?

\_\_\_ # of Drinks ENTER "0" IF DO NOT DRINK

79. **T1ALC1WK**

On average, how many days a week do you have an alcoholic drink?

\_\_\_ # of Days ENTER "0" IF DO NOT DRINK

**IF MEN,**

**AND >4 DRINKS PER DAY (T1DRINKS > 4), OR**

**>14 DRINKS PER WEEK (T1DRINKS \* T1ALC1WK), THEN ASK THE FOLLOWING TWO QUESTIONS**

**80. T1HURTMALC**

In the past 6 months, have you sometimes been under the influence of alcohol in situations where you could have caused an accident or gotten hurt?

1 ☐ Yes

2 ☐ No

**81. T1MOREMALC**

Have there often been times in the past 6 months when you had a lot more to drink than you intended to have?

1 ☐ Yes

2 ☐ No

**IF MEN >=65 OR WOMEN,**

**AND > 3 DRINKS PER DAY (T1DRINKS > 3), OR**

**> 7 DRINKS PER WEEK (T1DRINKS \* T1ALC1WK), THEN ASK THE FOLLOWING TWO QUESTIONS**

**82. T1HURTFALC**

In the past 6 months, have you sometimes been under the influence of alcohol in situations where you could have caused an accident or gotten hurt?

1 ☐ Yes

2 ☐ No

**83. T1MOREFALC**

Have there often been times in the past 6 months when you had a lot more to drink than you intended to have?

1 ☐ Yes

2 ☐ No

**84. H1PCPTLK**

Have you talked to your Primary Care Provider about drug or alcohol problems in the past 6 months?

1 ☐ Yes

2 ☐ No

→SKIP TO C1GREET

97 ☐ Don't Know/Refused

**85. H1SPKDOC**

How often in the past 6 months have you spoken with your Primary Care Provider about this?

1 ☐ Once

2 ☐ More than once

## PATIENT PROVIDER COMMUNICATION

### Communication Assessment Tool

We would like to know how you feel about the way your primary care physician has communicated with you in your last couple of visits. Your answers are completely confidential, so please be as open and honest as you can.

**86.** Please rate your physician's communication with you by marking **one box per row**.

| Statement                                                                    | Poor                       | Fair                       | Good                       | Very good                  | Excellent                  |
|------------------------------------------------------------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| <b>My doctor</b>                                                             |                            |                            |                            |                            |                            |
| <b>A. C1GREET</b><br>Greeted me in a way that made me feel comfortable       | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| <b>B. C1TXRSPT</b><br>Treated me with respect                                | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| <b>C. C1INSTIDEA</b><br>Showed interest in my ideas about my health          | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| <b>D. C1UNDHLTCNR</b><br>Understood my main health concerns                  | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| <b>E. C1ATTEN</b><br>Paid attention to me (looked at me, listened carefully) | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| <b>F. C1NOINTRPT</b><br>Let me talk without interruptions                    | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| <b>G. C1GVINFO</b><br>Gave me as much information as I wanted                | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| <b>H. C1TLKUNDSTD</b><br>Talked in terms I could understand                  | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| <b>I. C1CHKUNDSTD</b><br>Checked to be sure I understood everything          | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| <b>J. C1ENCASKQ</b><br>Encouraged me to ask questions                        | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| <b>K. C1INVDEC</b><br>Involved me in decisions as much as I wanted           | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| <b>L. C1DISFU</b><br>Discussed next steps, including any follow-up plans     | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| <b>M. C1CARECNR</b><br>Showed care and concern                               | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| <b>N. C1SPTTIME</b><br>Spent the right amount of time with me                | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |

## PEPPI Perceived Efficacy in Patient-Physician Interactions Questionnaire

87. Next, please rate your confidence level in your communication with your physician on a scale of 1 to 5, with 1 being "not at all confident" and 5 being "very confident".

| Statement                                                                                             | Not at all<br>confident    |                            |                            |                            | Very<br>Confident          |
|-------------------------------------------------------------------------------------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| <b>How confident are you in your ability to:</b>                                                      |                            |                            |                            |                            |                            |
| <b>A. P1DRATTN</b><br>Get a doctor to pay attention to what you have to say?                          | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| <b>B. P1KNWASKDC</b><br>Know what questions to ask a doctor?                                          | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| <b>C. P1DRANSQST</b><br>Get a doctor to answer all of your questions?                                 | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| <b>D. P1ASKDRHLTH</b><br>Ask a doctor questions about your chief health concern?                      | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| <b>E. P1VSMSTTDR</b><br>Make the most of your visit with the doctor?                                  | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| <b>F. P1DRSERHLTH</b><br>Get a doctor to take your chief health concerns seriously?                   | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| <b>G. P1UNDSTDR</b><br>Understand what a doctor tells you?                                            | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| <b>H. P1GTDRDOSM</b><br>Get a doctor to do something about your chief health concern?                 | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| <b>I. P1EXPDRHLTHCRN</b><br>Explain your chief health concern to a doctor?                            | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| <b>J. P1ASKMINF</b><br>Ask a doctor for more information if you don't understand what he or she said? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | 5 <input type="checkbox"/> |

*You have completed the 6 month questionnaire.*

*Thank you!*

### **List of common prescription opiate medications**

Buprenorphine  
Buprenorphine/Naloxone  
Butalbital with Codeine  
Butrans  
Codeine  
Darvocet  
Darvon  
Dihydrocodeine  
Duragesic (Fentanyl transdermal)  
Fentanyl  
Fiorinal with codeine  
Hydrocodone  
Kadian  
Levorphanol  
Meperidine or Demerol  
Methadone  
Morphine  
MS Contin  
Norco  
Nubain  
Opana  
Oramorph  
Oxycodone  
Oxycontin  
OxyFast OxyIR  
Oxymorphone  
Pentazocine  
Percocet  
Propoxyphene  
Reprexain  
Roxanol  
Roxicodone  
Suboxone  
Talwin  
Tramadol or Ultram  
Tylenol #3  
Tylox  
Vicodin  
Vicoprofen  
Zubsolv