Becker WC, Fiellin DA, Black AC, Kostovich CT, Kerns RD, Fraenkel L. Initial development of patient-reported instrument assessing harm, efficacy, and misuse of long-term opioid therapy. J Rehabil Res Dev. 2016;53(1):xx–xx. http://dx.doi.org/10.1682/JRRD.2014.11.0285

Appendix 2. Preliminary version of the PRIOR

Opioid pain medications are medications like oxycodone, hydrocodone, morphine, fentanyl, hydromorphone, or methadone.

In the past 30 days…

1. Have you felt depressed?
2. Have you had thoughts of hurting yourself?
3. Have you felt overly drowsy?
4. Have you felt sleepy or less alert when driving or using machinery?
5. Have you been in a car accident with you as the driver?
6. Have you fallen?
7. Have you been bothered by side effects of opioid pain medications?
8. Have side effects of opioid pain medications interfered with your work, family or other responsibilities?

In the past 30 days …

1. Have opioid pain medications been helpful in relieving your pain?
2. Is the amount of pain relief you are obtaining from opioid pain medications enough to make a real difference in your life?
3. Did pain interfere significantly with your day-to-day activities?
4. Have you been disabled by pain (unable to work or participate fully in activities)?

In the past 30 days…

1. Have you needed to take opioid pain medications more often than prescribed in order to relieve your pain?
2. Have you run out of opioid pain medications early and had to call for refills?
3. Did you use more of your medication, that is, take a higher dosage, than is prescribed for you?
4. Have you lost your opioid pain medications and needed them replaced?
5. Have others been worried about how you're handling your opioid pain medications?
6. Are you worried about how you're handling your opioid pain medications?
7. Have opioid pain medications caused you to have problems with family, friends, or coworkers?
8. Did using opioid pain medications cause you to have serious problems either at home, work, or school?
9. Have you felt that you could not control how much or how often you used opioid pain medications?
10. Have you thought constantly about use of opioid pain medications?
11. Have you wanted to stop using opioid pain medication or cut down on the amount of opioid pain medications that you use?
12. Have you been worried that you might be dependent on or addicted to opioid pain medications?
13. Have you had to visit the Emergency Room?
14. Have you gone to other doctors including emergency room doctors, seeking more opioid pain medications?
15. Have you had to go to someone other than your prescribing doctor to get enough pain relief from opioid pain medications?
16. Were you given opioid pain medications from more than one clinic?
17. Have family members or friends obtained opioid pain medications for you?
18. Have you needed to take opioid pain medications that belong to someone else?
19. Have you had to buy opioid pain medications on the street?
20. Did you use alcohol to help relieve some of the pain?
21. Did you feel high or get a buzz after using your pain medication?
22. Have you used opioid pain medications to help other symptoms such as problems sleeping?
23. Have you used opioid pain medications to help other symptoms such as being nervous or anxious?
24. Have you used the pain medications to help other symptoms such as depression?
25. Did you take opioid pain medication to relieve or cope with problems other than pain?

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