

Table 5.

Indiana Polyclinic STAR Evaluation*

Patient Name: _____ Date: _____

DOB: _____ / _____ / _____ MR#: _____

In regards to the last 12 months...

1. Have you felt depressed or anxious?	YES	NO	3
2. Have you noticed frequent mood swings?	YES	NO	2
3. Have you been unemployed?	YES	NO	1
4. Have you smoked cigarettes?	YES	NO	2
5. Have you felt that you smoke too much?	YES	NO	3
6. Have you drank more than three alcohol drinks per day most days?	YES	NO	4
7. Have you used recreational drugs?	YES	NO	4
8. Have you been treated for drug or alcohol problems?	YES	NO	4
9. Have you received pain medications from more than one doctor?	YES	NO	4
10. Have you been to more than one pain doctor or clinic?	YES	NO	1
11. Have you visited an emergency room for pain treatment?	YES	NO	2
12. Has anyone in your family (in or out of your home) had problems with drug or substance abuse?	YES	NO	3
13. Has there been any physical, sexual, or emotional abuse in your household?	YES	NO	2
14. Have you taken or borrowed prescription medication not prescribed to you?	YES	NO	4
15. Have you been arrested or had legal problems related to drugs or alcohol?	YES	NO	4

Total Score: _____

Key: 3, 10 = 1 2, 4, 11, 14 = 2 1, 5, 12, 13 = 3 6, 7, 8, 9, 15, 16 = 4

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Indiana Polyclinic STAR Evaluation*

Clinical Interpretation:

- High Risk (15+)
- Moderate Risk (7-14)
- Low Risk (0-6)

Plan:

- Maintain Current Tx Plan
- Modify Tx Plan (list below)
- Refer to Outside Agency (i.e. inpatient treatment, IOP)
- Other:

Supervisor Signature: _____ **Date:** _____

Clinician Signature: _____ **Date:** _____

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