BUPRENORPHINE MAINTENANCE TREATMENT

PATIENT INFORMATION

Intake questionnaire for treatment planning for a new patient

NAME ____________________________________ DATE________________

PLEASE ANSWER THE FOLLOWING QUESTIONS WHICH WILL HELP US DESIGN YOUR PLAN OF TREATMENT:

WHAT IS THE BEST TIME OF DAY AND DAY OF THE WEEK FOR OFFICE VISITS?

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ARE THERE ANY MONTHS OUT OF THE YEAR WHEN YOU MAY HAVE DIFFICULTY MAKING IT IN FOR A MONTHLY APPOINTMENT?

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IS THERE ANY PROBLEM THAT MAKES IT HARD FOR YOU TO GIVE ROUTINE URINE SPECIMENS?

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DO YOU HAVE ANY PROBLEMS THAT MAKE IT HARD FOR YOU TO READ LABELS OR COUNT PILLS?

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WHAT ARE YOUR REASONS FOR BEING INTERESTED IN BUPRENORPHINE TREATMENT?

ARE YOU CURRENTLY USING ANY ILLICIT DRUGS OR ALCOHOL? IF SO, WHAT ARE YOU USING?

IF YOU ARE NOT CURRENTLY USING DRUGS OR ALCOHOL, WHEN WAS THE LAST TIME YOU RELAPSED TO USE?

WHAT 'TRIGGERS' DO YOU KNOW WHICH HAVE PUT YOU IN DANGER OF RELAPSE IN THE PAST, OR WHICH MIGHT IN THE FUTURE?

WHAT COPING METHODS HAVE YOU DEVELOPED TO DEAL WITH THESE TRIGGERS TO RELAPSE?

ARE THERE ANY SPECIAL PLANS (SUCH A MAJOR TRIPS) THAT YOU HAVE FOR THE COMING YEAR?

WORK?____

HOME?____

OTHER?____

ARE THERE ANY SIGNIFICANT MEDICAL EVENTS (SUCH AS OPERATIONS) THAT YOU EXPECT YOU WILL NEED IN THE COMING YEAR?

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WHAT KINDS OF COUNSELING OR THERAPY HELP WOULD YOU LIKE FOR YOUR DRUG ABUSE PROBLEM?

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WHAT ARE YOUR STRENGTHS AND SKILLS TO HANDLE TAKE-HOME BUPRENORPHINE?

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WHAT WORRIES DO YOU HAVE ABOUT BEING RESPONSBILE FOR TAKING THIS MEDICATION ON YOUR OWN, AT HOME?

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IS ANYONE IN YOUR HOME ACTIVELY ADDICTED TO DRUGS OR ALCOHOL?

WHAT ARE THE MAJOR SOURCES OF STRESS IN YOUR LIFE?

ARE THERE ANY THINGS YOU WOULD PARTICULARLY LIKE TO DISCUSS WITH THE DOCTOR TODAY?

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