Naperville Suboxone Clinic

New Patient Intake form

Name:_____ Date:_____

Date of Birth: _____ Age:_____ Years of Use:_____

Please list all substances used:

SUBSTANCE USED	**Average Daily Use (total mg)**	**How taken (snort, IV, Oral Popping, Smoke)**	**Source (Prescription, street dealer, family, friend, other)**	**Years Used**	**Still Taking? (Y or N)**

Why are you seeking treatment now? _____

_____

When did you last use? _____ Substance Used?: _____

Allergies: _____

Current Medications: _____

WOMEN ONLY:

Method of birth control: _____ Date of Last Menstrual Period: _____

Is there a chance you might be pregnant? YES NO

PAST MEDICAL HISTORY:

Previous substance abuse treatment(s)_____ _____

Previous periods of abstinence:_____

Hepatitis: YES NO HIV: YES NO Other:_____ _____

SOCIAL HISTORY:

Tobacco Use: YES NO How many packs per day?:_____ How many years? _____ Trying to Quit? YES NO

EtOH (ethanol) Abuse: YES NO How Long?_____ Alcohol Abuse: YES NO How Long:_____

Treatment for alcohol abuse? YES NO If so, explain:_____

Living With:_____ Drug related divorce/ breakups: YES NO

Does your Spouse/Partner Use? YES NO Children? YES NO How Many?: _____ Custody? YES NO

Employed: YES NO Where:_____ Looking for a Job: YES NO

Job description:_____

Have you ever lost job to drug/alcohol abuse? YES NO When:_____

Have you had any legal issues: YES NO If so,Explain:_____ _____

Are you on probation? YES NO If so, Court Date:_____ Do you have history of DUI? YES NO

Have you ever been convicted/ arrested or in jail for any reason? YES NO If so, was it drug related? YES NO

Do you have valid drivers license? YES NO Do you have any transportation issues? YES NO

Is there any other stress in your life you would like to tell us about? _____

_____

FAMILY HISTORY: (please circle all that apply)

Family members with addiction issues: Father Mother Brother Sister Aunt Uncle Grandmother Grandfather Cousin

Suicide, Mental Illness. Axiety disorder : Father Mother Brother Sister Aunt Uncle Grandmother Grandfather Cousin

Other (diabetes, cancer, heart disease): Father Mother Brother Sister Aunt Uncle Grandmother Grandfather Cousin

If other, please explain:_____

NAME :_____DOB_____DATE_____

PLEASE CHECK ANY SYMPTOMS YOU CURRENTLY HAVE OR HAVE HAD IN THE LAST YEAR

GENERAL	**RESPIRATORY**	**DIET/LIFESTYLE**	**SKIN**	**MEN ONLY**
□ fever	□ asthma	□ vegetarian	□ rash	□ genital pain
□ chills	□ persistent cough	□ healthy diet	□ psoriasis	□ impotence
□ cramps	□ coughing blood	□ eat fried foods	□ shingles	□ genital sores
□ muscle aches	□ shortness of breath	□ eat much meat	□ dryness	□ lump in testicles
□ sweating	□ recurrent bronchitis	□ smoke	□ hair loss	□ penis discharge
□ weakness	□ phlegm production	□ drink alcohol	□ infection	□ nocturnal emission
□ fatigue	□ difficulty inhaling	□ drink coffee	□ sores	□ low sexual energy
□ dizziness	□ difficulty exhaling	□ eat a lot of sugar	□ ulcers	□ low libido
□ insomnia	□ wheezes	□ exercise excessively	□ blood not clotting	
□ allergies	□ tuberculosis	□ lack of exercise	□ bruise easily	**WOMEN ONLY**
□ weight gain/loss			□ discoloration	□ irregular periods
□ cramps	**CARDIOVASCULAR**	**GENITOURINARY**	□ swollen lymph node	□ heavy periods
□ cold hands/ feet	□ chest pain	□ night urination	□ acne	□ painful periods
□ low energy	□ high blood pressure	□ dark urine		□ breast lumps
□ hot flashes	□ low blood pressure	□ blood in urine	**NEUROLOGICAL**	□ low sexual energy
	□ irregular heart beat	□ kidney stones	□ seizures	□ low libido
NECK AND HEAD	□ poor circulation	□ dysuria	□ neuropathy	□ vaginal discharge
□ Migraines	□ ankle swelling	□ frequent urination	□ restless leg	□ menopausal
□ Cluster headaches	□ varicose veins	□ flank pain	□ carpel tunnel	□ uterine prolapse
□ Frequent headache	□ rib/ side pain	□ cloudy urine	□ tremor	□ facial hair
□ sore throat	□ murmur	□ burning urination	□ fainting	□ pain w/ intercourse
□ sinus		□ scanty urine	□ convulsions	PREGNANT? YES NO
□ runny nose	**GASTROINTESTINAL**	□ profuse urine	□ paralysis	
□ ear pain	□ GERD	□ bad bladder control	□ stroke	
□ congestion	□ heartburn	□ urgency to urinate	□ clumsiness	
□ blurred vision	□ acid reflux	□ prolapsed bladder	□ drowsiness	
□ heaviness in head	□ abdominal pain		□ vertigo	
□ phlegm in throat	□ nausea	**MUSCULOSKELETAL**	□ handwriting change	
□ cataracts	□ vomiting	PAIN, WEAKNESS		
□ double vision	□ diarrhea	NUMBNESS IN:	**EMOTIONAL**	
□ ear discharge	□ constipation	□ arms / legs	□ nervousness	
□ eye pain/strain	□ bloody stool	□ hands / feet	□ depression	
□ nasal obstruction	□ bloating	□ back	□ insomnia	
□ watery eyes	□ jaundice	□ hips	□ anorexia	
□ loss of sense smell	□ belching	□ neck	□ OCD	
□ hearing loss	□ gas	□ shoulders	□ suicidal ideation	
□ hoarseness	□ black stools	□ elbow/ knees	□ anger	
□ nosebleeds	□ hard swallowing	□ deformity	□ anxiety	
□ red/ sore eyes	□ hemorrhoids	□ arthritis	□ hearing voices	
□ ringing in ears	□ indigestion	□ injury	□ irritability	
□ corrected vision	□ stomach ache	□ chronic pain	□ forgetfulness	

SUBOXONE MAINTENANCE TREATMENT PATIENT INFORMATION

NAME _____ DATE OF BIRTH:_____DATE:_____

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

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

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

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

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?

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

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

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

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?

Naperville Suboxone Treatment

(Drug Abuse Screening Test) 10 Question

Patient_____DOB:_____

Date:_____Physician:_____

1. Have you used drugs other than those required for medical reasons?
2. Do you abuse more than one drug at a time?
3. Are you always able to stop using drugs when you want to?
4. Have you ever had blackouts or flashbacks as a result of drug use?
5. Do you ever feel bad or guilty about your drug use?
6. Does your spouse (or parents) ever complain about your involvement with drugs?
7. Have you ever neglected your family or missed work because of your use of drugs?
8. Have you ever engaged I illegal activities I order to obtain drugs?
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?
10. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions or bleeding)?

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12 Month Drug Use History

Patientt:_____DOB:_____

Physician:_____

In the following statements “drug abuse” refers to

- The use of prescribed or over the counter drugs in excess of the directions.
- Any nonmedical use of drugs.
- The various classes of drugs may include cannabis, solvents, tranquilizers, barbiturates, cocaine, stimulants hallucinogens or narcotics.
- The questions do not include use of alcohol.

PLEASE ANSWER EVERY QUESTION. IF YOU HAVE DIFFICULTY WITH A QUESTION THEN CHOOSE THE ANSWER THAT IS MOSTLY RIGHT.

These Questions Refer to the Past 12 Months			
1	Have you used drugs other than those required for medical reasons?	yes	no
2	Do you abuse more than one drug at a time?	yes	no
3	Are you always able to stop using using drugs when you want to?	yes	no
4	Have you ever had blackouts or flashbacks as a result of using drugs?	yes	no
5	Do you ever felt bad or guilty about your drug use?	yes	no
6	Does your spouse (family members) ever complain about your drug involvement?	yes	no
7	Have you neglected your family because of your use of drugs?	yes	no
8	Have you engaged in illegal activites in order to obtain drugs?	yes	no
9	Have you ever had withdrawal symptoms (felt sick)when you stopped taking drugs?	yes	no
10	Have you had any medical problems as a result of drug use?	yes	no

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(Subjective Opiate Withdrawal Scale)

Patient Name:_____DOB_____

Date:_____ _____Time_____

Insturctions:
Answer the following statements as accurately as you can. Circle the answer that best fits the way you feel now. The total sum of item ratings, and ranges from 0 -64

0= Not at all
1= A little
2= Moderately
3= Quite A Bit
4= Extremely

		Not at all	A little	Moderately	Quite a bit	Extremely
1	I feel anxious	0	1	2	3	4
2	I feel like yawning	0	1	2	3	4
3	I am perspiring	0	1	2	3	4
4	My eyes are tearing	0	1	2	3	4
5	My nose if running	0	1	2	3	4
6	I have gooseflesh	0	1	2	3	4
7	I am shaking	0	1	2	3	4
8	I have hot flashes	0	1	2	3	4
9	I have cold flashes	0	1	2	3	4
10	My bones and muscles ache	0	1	2	3	4
11	I feel restless	0	1	2	3	4
12	I feel nauseous	0	1	2	3	4
13	I feel like vomiting	0	1	2	3	4
14	My muscles twitch	0	1	2	3	4
15	I have cramps in my stomach	0	1	2	3	4
16	I feel like shooting up now	0	1	2	3	4

Patient Rights: Confidentiality and Consent for Naperville Suboxone Treatment

As a patient getting treatment for a substance use disorder, your personal and medical information is protected under United States confidentiality law. This law states that your provider is not allowed to tell anyone the reason you are being treated, without your permission. Providers and treatment programs that provide addiction treatment are not even allowed to tell anyone whether or not you are a patient.

Patient Consent

With your approval --sometimes called consent -- your provider may let others, such as your insurance company or your family, know about your treatment. No information will be released unless you sign a consent form, which will include the name of your provider or treatment provider, the person/group to whom your information is going, the purpose of the disclosure, how much information may be communicated, when the consent form expires, and the date. Even if you sign a consent form, you have the right to change your mind at any time. If you do change your mind, your provider will not share any additional information with others.

Impact on Treatment

The confidentiality law is strict, but it will not keep you from getting good treatment. Exceptions were written into the law to make sure that patients still get excellent care. For instance, information can be shared among treatment staff in order to provide you with better treatment. Also, the law takes into account unexpected things that might happen. For instance, if there is a medical emergency and if they need to know, the medical personnel treating you can be told that you are receiving maintenance treatment for a substance use disorder.

The Last Word

Remember, the confidentiality law was set up to protect your rights. Ask your provider if you have more questions about confidentiality or consent.

Name:_____**Date:**_____

Signature:_____