|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | Client Number: |  |

## Past Medical and Surgical Histories: List any medical diagnoses, psychiatric illnesses, and surgeries you have had.

## Family Medical History: List any medical diagnoses and psychiatric illnesses in the family.

Anyone with opioid use disorder?
Anyone with alcohol use disorder?

## Medications: List medications you currently take including over the counter, herbals, and alternative medications.

|  |  |  |
| --- | --- | --- |
| Medication Name | Dose and Frequency | Reason for use |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

## Allergies to Medications:

Current Primary Care Physician:
Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current Psychiatrist:
Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Former psychiatrist?
Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Location:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had a counselor or a therapist?

Did you find your counselor helpful?

If no, please describe:

## Details of Opioid Use:

|  |  |
| --- | --- |
| How old were you when you first used opioids?  |  |
| Were the opioid prescribed?  |  |
| Did you use opioids for energy?  |  |
| Did you use opioids for a high?  |  |
| Did you use opioids for as an escape?  |  |
| When did you take your last opioid? |  |
| When do you expect your withdrawal symptoms to start? |  |
| When do you expect your withdrawal symptoms to peak? |  |
| Have you had any severe complications from withdraw? |  |
| Have you been hospitalized for withdrawal? |  |
| Which substances have you used in the last 7 days?  |  |
|  | Any benzodiazepines?  |  |
|  | Any alcohol?  |  |
| Have you ever taken methadone?  |  |
| Have you ever taken Suboxone?  |  |
|  | Have you ever **injected** Suboxone? |  |
|  | Have you ever **snorted** Suboxone? |  |
| Have you ever taken naltrexone?  |  |
| What do you hope to gain from treatment?  |  |

## Criteria for Opioid use Disorder

Mark yes to all the following that apply to your **opioid use in the last 12 months.**

|  |  |
| --- | --- |
| 1. Taken in larger quantities or longer time than intended
 |  |
| 1. Persistent desire or unsuccessful efforts to cut down or control use
 |  |
| 1. A great deal of time spent in activities related to or recovering from effects
 |  |
| 1. Craving or a strong desire to use
 |  |
| 1. Recurrent use resulting in failure to fulfill major role obligations at work, school, home
 |  |
| 1. Continued use despite recurrent problems at work, relationships
 |  |
| 1. Important social, family, or job-related activities given up or reduced as a result of use
 |  |
| 1. Recurrent use in situations potentially physically hazardous (driving, heavy machinery)
 |  |
| 1. Continued use despite knowledge of having psychological problems due to use
 |  |
| 1. Tolerance (need increased amount, diminished effect with same amount)
 |  |
| 1. Withdrawal (withdrawal symptoms or taking opioids to prevent withdrawal)
 |  |

## Do any of the above apply to other drugs you have used in the last 12 months?

## Prior Treatments

|  |  |  |  |
| --- | --- | --- | --- |
| Addiction Treatment Facility | Location | Year | Medication Used and side effects experienced |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Alternative therapies:

Do you participate in alternative therapies? Reiki, meditation, massage, acupuncture, ect.

If so, please list:

Drug Use Consequences:

|  |  |
| --- | --- |
| How many times have you overdosed on opioids? |  |
| Have you ever had a cardiac arrest?  |  |
| Have you had injuries while using? |  |
|  | List injuries:  |  |
| Do you have any drug-related medical issues? |  |
|  | List medical issues:  |  |
|  | Have you had a severe head injury? |  |
|  | Have you had a traumatic brain injury? |  |
|  | Have you been in a coma? |  |
|  | Have you had a concussion? |  |
|  | Have you had any seizures?  |  |
| Do you have any drug-related psychiatric issues? |  |
|  | Have you ever attempted suicide? |  |
|  |  If so, how many? |  |
|  | Have you had psychiatric hospitalizations? |  |
|  |  If so, how many? |  |
| Have you traded or sold sex for drugs? |  |
|  | Have you received education on HIV? |  |
|  | Have you received education on Hepatitis? |  |
|  | Have you received education on Sexually Transmitted Infections? |  |
| Have you ever sold drugs? |  |
| Have you ever used a needle to inject drugs?  |  |
|  | Have you shared needles?  |  |
|  | Do you have track marks? |  |
|  | What substances have you injected? |  |
|  | When did you last inject your drugs?  |  |

## Recovery Skills and Living Environment:

|  |  |
| --- | --- |
| What is your longest period of sobriety?  |  |
|  | When was this? |  |
|  | What treatment were you on at the time? |  |
| Do other people in your life current use drugs? |  |
|  | If so, who? Do not list names  |  |
| How many sober supports do you have?  |  |
| Does your family know you are seeking treatment? |  |
| What’s the highest grade you completed in school? |  |
|  |  |

Risk taking behaviors:

|  |  |
| --- | --- |
| Do you harm yourself via cutting or other means? |  |
| Share needles? |  |
| Have unprotected sex? |  |
| Engage in extreme sports? |  |
| Drive at excessive speeds? |  |
| Drive under the influence? |  |

For Women:

|  |  |
| --- | --- |
| What is your current form of birth control? |  |
| How many pregnancies have you had? |  |
| How many live births? |  |
| Are you currently pregnant?  |  |
| First day of your last period? |  |