BUPRENORPHINE/NALOXONE MAINTENANCE TREATMENT

INTAKE QUESTIONNAIRE FOR PATIENT
TREATMENT-PLANNING QUESTIONS

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 YOU FOR CLINIC VISITS?

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

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

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

WHAT ARE YOUR REASONS FOR BEING INTERESTED IN BUPRENORPHINE/NALOXONE TREATMENT?

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?

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WHAT PLANS DO YOU HAVE FOR THE COMING YEAR?
WORK?_____
HOME?_____
OTHER?_____

WHAT KINDS OF HELP WOULD YOU LIKE FROM YOUR COUNSELOR?
_____
_____

WHAT ARE YOUR STRENGTHS AND SKILLS TO HANDLE TAKE-HOME BUPRENORPHINE/NALOXONE (SUBOXONE)?
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_____

WHAT WORRIES DO YOU HAVE ABOUT EXTENDED TAKE-HOMES?
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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?
_____

WHAT FAMILY OR SIGNIFICANT OTHERS WILL BE SUPPORTIVE TO YOU DURING YOUR TREATMENT?

WOULD YOU BE WILLING TO SIGN A RELEASE SO THAT THE PERSON(S) IDENTIFIED ABOVE CAN BE SPOKEN TO REGARDING YOUR TREATMENT?

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WHAT MEDICAL CARE WILL YOU HAVE IN THE COMING YEAR?
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HOW WILL YOU COMPLY WITH THE ANNUAL PHYSICAL EXAMINATION AND LABORATORY AND URINE TESTING REQUIREMENTS?_____

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HAVE YOU EVER BEEN TREATED FOR A PSYCHIATRIC PROBLEM OR MENTAL ILLNESS OR PRESCRIBED PSYCHIATRIC MEDICATIONS?

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