THE HEAG
PAIN MANAGEMENT CENTER, P.A.

Patient Name: _____ D.O.B._____ Date: _____

Therapy Progress Report

SUBOXONE®© (buprenorphine HCl/naloxone HCl dehydrate) sublingual tablet

Please answer the questions using the following scale:					
	0 = not at all				4 = extremely
NOW	0	1	2	3	4
1. I feel anxious	○	○	○	○	○
2. I feel like yawning	○	○	○	○	○
3. I am perspiring	○	○	○	○	○
4. My nose is running and/or my eyes are watery	○	○	○	○	○
5. I have goose bumps and/or chills	○	○	○	○	○
6. I feel nauseated or like I may need to vomit	○	○	○	○	○
7. I have stomach cramps and/or diarrhea	○	○	○	○	○
8. My muscles twitch	○	○	○	○	○
9. I feel dehydrated and/or have not had much appetite	○	○	○	○	○
10. I am having difficulty sleeping	○	○	○	○	○
11. I have a headache	○	○	○	○	○
12. My muscles and bones ache	○	○	○	○	○
13. I feel like using right now	○	○	○	○	○
14. I would rate my overall level of withdrawal as:	○	○	○	○	○
15. Do you feel you need a dosage change?	○ No	○ Yes	○ Up	○ Down	
16. Have you used alcohol or drugs since your last visit?	○ No	○ Yes			
If yes, please describe what, when and how much: _____					
Please describe the problems or situations you found most stressful during the past week (if needed, use back of page): _____					

Completed by Physician

S/O)	
A)	P)

_____

Physician Signature Date