Patient Name: ______________________________________ D.O.B.__________________ Date: __________________

Patient Intake – Medical History
(Opioid-Dependent Treatment)

(To be completed by patient)

Name:____

Address: ____

City: _________________________________ State: ________________________________ Zip: _______________

Phone: (work) _________________________ (home) ________________________ (cell) ____________________

D.O.B.: ____________________________ Age: _______________ SS#: ____________________________________

Emergency Contact: ____

Relationship to Patient: ____________________________________ Phone: _________________________________

Primary Care Physician: ____________________________________ Phone: _________________________________

Date of last physical: ________________ Have you ever had an EKG? ___ Yes ___ No Date: _________________

Past Medical History

Current Medications

What medications are you currently taking? (please list)

Medication	Strength or Dosage	How Often do Take this Medication	Why do you take this Medication	Who Prescribed This Medication

____

Patient Signature

Patient Name: ______________________________________ D.O.B.__________________ Date: __________________

Past Medical History (cont'd)

Allergies

Do you have any allergies? (please list) ____

____

____

Past Surgical History

Please List

Date	Type of Operation	Complications (describe)

Metal

Do you have any metal in your body? ☐ Yes ☐ No

Blood Thinner

Do you take Coumadin or any other blood thinner? ☐ Yes ☐ No

____
Patient Signature

Patient Name: ______________________________________ D.O.B.___________________ Date: __________________

Past Medical History (cont'd)

Prior Illness or Accidents

In what situation did your present pain originally begin? (choose one)

- ☐ Accident or injury at home
- ☐ Accident or injury (other)
- ☐ Following surgery
- ☐ Accident or injury at work
- ☐ Related to illness
- ☐ No apparent reason

Explain: ____

____

Have you had any of the following problems?

Heart:	☐ Stroke	☐ Heart Attack	☐ High Blood Pressure
	☐ Blocked Arteries (head, neck, arm, etc.)	☐ Angina	
Lungs:	☐ Emphysema	☐ TB	☐ Asthma/Respiratory
	☐ Pneumonia	☐ Obstructive Sleep Apnea	
Nerves:	☐ Anxiety	☐ Depression	☐ Numbness
	☐ Weakness	☐ Dizziness	☐ Epilesy/Seizure Disorder
Stomach/Bowels:	☐ Bleeding Ulcers	☐ Hiatal Hernia/Reflux	☐ Constipation
	☐ GI Disease		
	☐ Meds Cause trouble		
Kidneys/Liver:	☐ Kidney Failure	☐ Cirrhosis	☐ Yellow Jaundice
Glands:	☐ Low or High Thyroid	☐ Diabetes Mellitus	☐ Cancer
Joints:	☐ Rheumatoid Arthritis	☐ Muscle Disease	☐ Osteoarthritis
Blood:	☐ Low or high blood counts	☐ Clotting	☐ Easy or Free Bleeding
Misc:	☐ Head Trauma	☐ STDs	☐ HIV/AIDS
	☐ Pancreatic Problems	☐ Abnormal Pap Smear	

Other: ____

____

____
Patient Signature

Patient Name: ____ D.O.B.__________________ Date: __________________

Past Medical History (cont'd)

Childhood Illnesses

Measles: ☐ Yes ☐ No Mumps: ☐ Yes ☐ No Chicken Pox: ☐ Yes ☐ No

Tobacco History

Cigarettes: Now? ☐ Yes ☐ No In the past? ☐ Yes ☐ No

How many per day on average? _______________ For how many years? __________________

Pipe: Now? ☐ Yes ☐ No In the past? ☐ Yes ☐ No

How often per day? _______________ For how many years? __________________

Have you ever been treated for substance misuse? ☐ Yes ☐ No

Please describe when, where, and for how long: ____

____

____

How long have you been using substances? ____

Substance Use History

	No	Yes/Past or Yes/Now	Route	How Much	Date/Time of Last Use	Quantity Last Used
Alcohol						
Caffeine (pills or beverages)						
Cocaine						
Crystal Meth-amphetamine						
Heroin						
Inhalants						
LSD or hallucinogens						

Patient Name: ____ D.O.B.____________________ Date: ___________________

Substance Use History (cont'd)						
	No	**Yes/Past or Yes/Now**	**Route**	**How Much**	**Date/Time of Last Use**	**Quantity Last Used**
Marijuana						
Methadone						
Pain killers						
PCP						
Stimulants (pills)						
Tranquilizers/Sleeping Pills						
Ecstasy						
Other:						

Did you ever stop using any of the above because of dependence? ☐ Yes ☐ No

Please list: ____

____

____

What was your longest period of abstinence? ____

____

Patient Signature

Patient Name: ____ D.O.B.__________________ Date: __________________

Social/Family History

Current occupation or last job: ____

Present employment status:

☐ Full time ☐ Part time ☐ Student ☐ Unemployed
☐ Retired ☐ Leave of Absence ☐ Homemaker

What type of work do/did you do? ____

How long have/did you work there? ____

If you are current not working when was you last day of work? Date:____________________________________

Marital Status (choose one):

☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Remarried

Years Married: ____________ Times Married: ____________ Times Divorced: ___________

Children? ☐ Yes ☐ No Current ages: _____________________________________

Residing with you? ☐ Yes ☐ No If no, where: ______________________________________

Present living situation (If living with more than one individual, check primary head of household):

☐ Alone ☐ With spouse ☐ With children
☐ With parents ☐ With friend ☐ With other family members

Do you have family nearby? ☐ Yes ☐ No Describe: _________________________________

Have you ever been arrested or convicted? ☐ Yes ☐ No

☐ DWI ☐ Drug-related ☐ Domestic Violence ☐ Other

Have you ever been abused? ☐ Yes ☐ No

☐ Physically ☐ Sexually (including rape or attempted rape) ☐ Verbally ☐ Emotionally

Have you ever attended:

AA: ☐ Current ☐ Past
NA: ☐ Current ☐ Past

If you are not currently attending meetings, what factors led you to stop? __________________________________

____

Have you ever been in counseling or therapy? ☐ Yes ☐ No

Please describe: ____

Education (check highest grade/degree completed):

☐ Less than 8th grade ☐ Completed 8th grade ☐ Some high school
☐ High school graduate ☐ Some college ☐ College graduate
☐ Advanced degree

____

Patient Signature

Patient Name: ______________________________________ D.O.B.___________________ Date: __________________

Family Medical History

Has a member of your family ever had any of the following conditions?

			Family Member (mother, father, etc.)
Anemia	☐ Yes	☐ No	
Anxiety	☐ Yes	☐ No	
Arthritis	☐ Yes	☐ No	
Asthma	☐ Yes	☐ No	
Benign Prostatic Hyperplasia	☐ Yes	☐ No	
Back Problems	☐ Yes	☐ No	
Breast Cancer	☐ Yes	☐ No	
Coronary Artery Disease	☐ Yes	☐ No	
Congestive Heart Failure	☐ Yes	☐ No	
Chronic Obstructive Pulmonary Disease	☐ Yes	☐ No	
Cancer	☐ Yes	☐ No	
Cholesterol – High	☐ Yes	☐ No	
Dementia	☐ Yes	☐ No	
Depression	☐ Yes	☐ No	
Dermatitis	☐ Yes	☐ No	
Diabetes	☐ Yes	☐ No	
Epilepsy	☐ Yes	☐ No	
GERD	☐ Yes	☐ No	
Glaucoma	☐ Yes	☐ No	
Gout	☐ Yes	☐ No	
HIV	☐ Yes	☐ No	
Headache	☐ Yes	☐ No	
Hepatitis	☐ Yes	☐ No	
Hypertension	☐ Yes	☐ No	
Myocardial Infarction	☐ Yes	☐ No	
Migraine	☐ Yes	☐ No	
Pneumonia	☐ Yes	☐ No	
Renal Stone	☐ Yes	☐ No	
Stroke	☐ Yes	☐ No	
Tuberculosis	☐ Yes	☐ No	
Thyroid Disease	☐ Yes	☐ No	
Ulcer	☐ Yes	☐ No	

Is there a family history of anything **NOT** listed here? (please explain) ____

____

____
Patient Signature

Patient Name: ______________________________________ D.O.B.___________________ Date: __________________

Drug Abuse Screening Test

	Question	Yes	No
1.	Have you used drugs other than those required for medical reasons?	Yes	No
2.	Have you abused prescription drugs?	Yes	No
3.	Do you abuse more than one drug at a time?	Yes	No
4.	Can you get through the week without using drugs (other than those required for medical reasons)?	Yes	No
5.	Are you always able to stop using drugs when you want to?	Yes	No
6.	Do you abuse drugs on a continuous basis?	Yes	No
7.	Do you try to limit your drug use to certain situations?	Yes	No
8.	Have you had "blackouts" or "flashbacks" as a result of drug use?	Yes	No
9.	Do you ever feel bad about your drug abuse?	Yes	No
10.	Does your spouse (or parents) ever complain about your involvement with drugs?	Yes	No
11.	Do your friends or relatives know or suspect you abuse drugs?	Yes	No
12.	Has drug abuse ever created problems between you and your spouse?	Yes	No
13.	Has any family member ever sought help for problems related to your drug use?	Yes	No
14.	Have you ever lost friends because of your use of drugs?	Yes	No
15.	Have you ever neglected your family or missed work because of your use of drugs?	Yes	No
16.	Have you ever been in trouble at work because of drug abuse?	Yes	No
17.	Have you ever lost a job because of drug abuse?	Yes	No
18.	Have you gotten into fights when under the influence of drugs?	Yes	No
19.	Have you ever been arrested because of unusual behavior while under the influence of drugs?	Yes	No
20.	Have you ever been arrested for driving while under the influence of drugs?	Yes	No
21.	Have you engaged in illegal activities to obtain drugs?	Yes	No
22.	Have you ever been arrested for possession of illegal drugs?	Yes	No
23.	Have you ever experienced withdrawal symptoms as a result of heavy drug intake?	Yes	No
24.	Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, or bleeding)?	Yes	No
25.	Have you ever gone to anyone for help for a drug problem?	Yes	No
26.	Have you ever been in hospital for medical problems related to your drug use?	Yes	No
27.	Have you ever been involved in a treatment program specifically related to drug use?	Yes	No
28.	Have you been treated as an outpatient for problems related to drug abuse?	Yes	No

Scoring: Each positive response yields 1 point, except for questions 4, 5, and 7 which yield 1 point for a negative response or false direction. A score greater than 5 requires greater evaluation for substance misuse problems.

____

Patient Signature

Patient Name: ____________________________________ D.O.B.__________________ Date: _________________

TREATMENT AGREEMENT – CONDITION TERMS FOR TREATMENT

As a participant in buprenorphine treatment for opioid misuse and dependence, I freely and voluntarily agree to accept this treatment contract as follows:

1. I agree to keep and be on time to all my scheduled appointments.
2. I agree to adhere to the payment policy outlined by this office.
3. I agree to conduct myself in a courteous manner in the doctor’s office.
4. I agree not to sell, share, or give any of my medication to another person. I understand that such mishandling of my medication is a serious violation of this agreement and would result in my treatment being terminated without any recourse for appeal.
5. I agree not to deal, steal, or conduct any illegal or disruptive activities in the doctor’s office.
6. I understand that if dealing or stealing or if any illegal or disruptive activities are observed or suspected by employees of the pharmacy where my buprenorphine is filled, that the behavior will be reported to my doctor’s office and could result in my treatment being terminated without any recourse for appeal.
7. I agree that my medication/prescription can only be given to me at my regular office visits. A missed visit may result in my not being able to get my medication/prescription until the next scheduled visit.
8. I agree that the medication I receive is my responsibility and I agree to keep it in a safe, secure place. I agree that lost medication will not be replaced regardless of why it was lost.
9. I agree not to obtain medications from any doctors, pharmacies, or their sources without telling my treating physician.
10. I understand that mixing buprenorphine with other medications, especially benzodiazepines (for example, Valium®, Klonopin®, or Xanax®), can be dangerous. I also recognize that several deaths have occurred among persons mixing buprenorphine and benzodiazepines (especially if taken outside the care of a physician, using routes of administration other than sublingual or in higher than recommended therapeutic doses).
11. I agree to take my medication as my doctor has instructed and not to alter the way I take my medication without first consulting my doctor.
12. I understand that medication alone is not sufficient treatment for my condition, and I agree to participate in counseling as discussed and agreed upon with my doctor and specified in my treatment plan.
13. I agree to abstain from alcohol, opioids, marijuana, cocaine, and other addictive substances (excepting nicotine).
14. I agree to provide random urine samples and have my doctor test my blood alcohol level.
15. I understand that violations of the above may be grounds for termination of treatment.

____

Patient Signature Date

____

Physician Signature Date

Patient Name: ______________________________________ D.O.B.___________________ Date: __________________

Appointed Pharmacy Consent

SUBOXONE® (buprenorphine HCL/naloxone HCL dehydrate) sublingual tablet
SUBUTEX® (buprenorphine HCL) sublingual tablet

I ____do hereby: (MD check all that apply)
Patient Name (print)

- ☐ Authorize __________________________________ to disclose my treatment for opioid dependence to
  Physician Name (print)
  employees of the pharmacy specified below. Treatment disclosure most often includes, but may not be limited to, discussing my medications with the pharmacist, and faxing/calling in my buprenorphine prescriptions directly to the pharmacy
- ☐ Agree to allow pharmacist to contact physician listed above to discuss my treatment if necessary so that my buprenorphine prescriptions can be filled and either delivered to the office address given above or picked up by employees of the same.

I understand that I may withdraw this consent at any time, either verbally or in writing, except to the extent that action has been taken in reliance on it. This consent will last while I am being treated for opioid dependence by the physician specified above unless I withdraw my consent during treatment. This consent will expire 365 days after I complete my treatment, unless the physician specified above is otherwise notified by me.

I understand that the records to be released may contain information pertaining to psychiatric treatment and/or treatment for alcohol and/or drug dependence. These records may also contain confidential information about communicable diseases including HIV (AIDS) or related illness. I understand that these records are protected by the Code of Federal Regulations Title 42 Part 2 (42 CFR Part 2) which prohibits the recipient of these records from making ay further disclosures to third parties without the express written consent of the patient.

I acknowledge that I have been notified of my rights pertaining to the confidentiality of my treatment information/records under 42 CFR Part 2, and I further acknowledge that I understand those rights.

____ ____________________________
Patient Signature Date

____ ______________________________________ ______________
Parent/Guardian Signature Parent/Guardian Name (print) Date

____ ______________________________________ ______________
Witness Signature Witness Name (print) Date

Appointed Pharmacy: Name: ____ Phone: ______________________

Address: ____

Patient Name: ______________________________________ D.O.B.___________________ Date: __________________

Balance Self-Test – Are You At Risk For Falls?

	Question	Yes	No
1.	Have you fallen in the past year?	Yes	No
2.	Do you lose your balance when you are standing?	Yes	No
3.	Do you lose your balance when you initially get up after sitting?	Yes	No
4.	Do you get dizzy, faint or have seizures?	Yes	No
5.	Does it take you more than one try to get up out of a chair or bed?	Yes	No
6.	Do you trip over your own feet or objects on the floor?	Yes	No
7.	Do you take corners too sharp, bump into corners or door frames?	Yes	No
8.	Do you use a walker, cane or need assistance to get around?	Yes	No
9.	Do you lose your balance, feel unsteady or stagger when walking?	Yes	No
10.	Have you had a recent loss or decrease in vision or hearing?	Yes	No
11.	Do you have numbness or loss of sensation in your feet or legs?	Yes	No
12.	Have you experienced a stroke, accident, or any other health problems that may have affected your balance?	Yes	No

If you have answered yes to one or more questions, you may have a balance problem. If you are concerned about falling, you should speak with your physician.

Patient Signature: ____ Date: ____________________