



**Siblings (Include names, ages/marital status/occupation/nieces or nephews)** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Please list referral source:**

\_\_\_\_\_

Referral Source

\_\_\_\_\_

Phone Number of Referral Source

**EMERGENCY CONTACT**

**Name** \_\_\_\_\_ **Relationship to you** \_\_\_\_\_

**Daytime Phone:** \_\_\_\_\_ **Cell Phone** \_\_\_\_\_

**Evening Phone** \_\_\_\_\_

**Opioid of Choice:** \_\_\_\_\_

**How taken ?eg. Oral, inhaled, injected):** \_\_\_\_\_

**Current Number of Times per Day Used:** \_\_\_\_\_

**Current Amount Spent per Use:** \_\_\_\_\_

**Last Use (Date and Time):** \_\_\_\_\_

**Present Symptoms:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Have you ever overdosed either intentionally or unintentionally on any drug?**

**Yes** \_\_\_\_\_ **No** \_\_\_\_\_ **If yes, give details including date(s), drug(s),**

**treatment and location of treatment.** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**History of Drug Abuse Treatment:** \_\_\_\_\_

\_\_\_\_\_

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**Please describe your relapses (if you've had relapses). Include information on**

**What triggered the relapse, drugs associated with relapse, etc.** \_\_\_\_\_

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**Are you currently receiving counseling or therapy for your addiction?**

**Yes** \_\_\_\_\_ **No** \_\_\_\_\_ **If yes, for how long, where and with whom** \_\_\_\_\_

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**Do you attend any 12-Step Recovery Programs? Yes** \_\_\_\_\_ **No** \_\_\_\_\_

**If yes, which one(s) and how frequently** \_\_\_\_\_

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**Have you experienced withdrawal? Yes** \_\_\_\_\_ **No** \_\_\_\_\_

**Describe your withdrawal symptoms** \_\_\_\_\_

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**Do you have a family history of addiction (drugs or alcohol)? Yes** \_\_\_\_\_ **No** \_\_\_\_\_

**If yes, please give details:** \_\_\_\_\_

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**Why are you seeking treatment for your addiction at this time?** \_\_\_\_\_

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**Have you been ordered by the courts or your employer to attend a treatment**

**program? Yes** \_\_\_\_\_ **No** \_\_\_\_\_

Are you currently employed? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, what do you do? \_\_\_\_\_

Is anyone aware of your addiction problem? Yes \_\_\_\_\_ No \_\_\_\_\_

Are they supportive of you seeking treatment? \_\_\_\_\_  
\_\_\_\_\_

## Medical History

Allergies: \_\_\_\_\_

Current medications (include over the counter medications): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medical /Psychiatric Problems: \_\_\_\_\_  
\_\_\_\_\_

Have you ever tried to commit suicide? Yes \_\_\_\_\_ No \_\_\_\_\_

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? \_\_\_\_\_

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**What coping methods have you developed to deal with these triggers to relapse?**

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**Are there any special plans (such as major trips) that you have for the coming year?**

**Work** \_\_\_\_\_

**Home** \_\_\_\_\_

**Other** \_\_\_\_\_

**Are there any significant medical events (such as surgery) that you expect you will need in the coming year?** \_\_\_\_\_

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**What kinds of counseling or therapy are you currently receiving for your drug abuse problem?** \_\_\_\_\_

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**What are your strengths and skills to handle take-home Buprenorphine?**

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**What worries do you have about being responsible 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 issues that you would particularly like to discuss with the doctor?**  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_