

# BUPRENORPHINE MAINTENANCE TREATMENT

## PATIENT INFORMATION

### **Intake questionnaire for treatment planning for a new patient**

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 OFFICE VISITS?

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

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

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

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WHAT ARE YOUR REASONS FOR BEING INTERESTED IN BUPRENORPHINE TREATMENT?

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ARE YOU CURRENTLY USING ANY ILLICIT DRUGS OR ALCOHOL? IF SO, WHAT ARE YOU USING?

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IF YOU ARE NOT CURRENTLY USING DRUGS OR ALCOHOL, WHEN WAS THE LAST TIME YOU RELAPSED TO USE?

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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 A MAJOR TRIPS) THAT YOU HAVE FOR THE COMING YEAR?

WORK? \_\_\_\_\_

HOME? \_\_\_\_\_

OTHER? \_\_\_\_\_

ARE THERE ANY SIGNIFICANT MEDICAL EVENTS (SUCH AS OPERATIONS) THAT YOU EXPECT YOU WILL NEED IN THE COMING YEAR?

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WHAT KINDS OF COUNSELING OR THERAPY HELP WOULD YOU LIKE 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?

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IS ANYONE IN YOUR HOME ACTIVELY ADDICTED TO DRUGS OR ALCOHOL?

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WHAT ARE THE MAJOR SOURCES OF STRESS IN YOUR LIFE?

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ARE THERE ANY THINGS YOU WOULD PARTICULARLY LIKE TO DISCUSS WITH THE DOCTOR TODAY?

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