OPIOID USE INTAKE FORM

Name: _____ DOB:_____

Address: _____Apt #: _____

City: _____ State: _____ Zip: _____

Phone: (_____)_____ VM message OK? Yes / No Preferred number? Yes / No

(_____)_____ VM message OK? Yes / No Preferred number? Yes / No

(_____)_____ VM message OK? Yes / No Preferred number? Yes / No

E-mail: _____

OK to contact you by e-mail? Yes / No
*Please note e-mail correspondence may not be encrypted and may not be confidential. _____ (*please initial*)

How do you identify your ethnicity? African-American Asian Caucasian Latino

Pacific Islander Bi-racial Multi-racial Other: _____

Insurance Carrier: _____ Policy #: _____

Person financially responsible for your treatment (*if other than you*)

Name: _____

Relationship to you: _____

Address: _____Apt #: _____

City: _____ State: _____ Zip: _____

Phone: (_____)_____

E-mail: _____

Emergency Contact: _____

Relationship to you _____

Phone: (_____)_____

Primary care physician: _____

Phone: (_____)_____ Referred? Yes / No

Approximate date of most recent lab work: _____

Where: _____

Psychiatrist: _____

Phone: (_____)_____ Referred? Yes / No

Therapist/Counselor: _____

Phone: (_____)_____ Referred? Yes / No

Name of referring person, if not above: _____

Phone: (_____)_____

Opioid Use History

When was the first time you used an opioid (heroin or painkiller)? _____

Name of drug: _____

☐ Oral (*by mouth*) ☐ Snorted ☐ Smoked ☐ Injected

Prescribed by a physician? Yes / No If yes, did you use as directed? Yes / No

If no, please explain: _____

Have you used other types of opioid drugs? Yes / No

If yes, please list them: _____

When did you begin using an opioid every day? _____

When did you first became dependent, or get sick if you did not use regularly? _____

_____

Have you ever injected opioids or other drugs? Yes / No

Have you had any periods when you did not use opioids? Yes / No

If yes, approximate dates when you were opioid free: _____

How did you stop? ☐ on your own ☐ with outpatient treatment, therapy, or a self-help group

☐ live-in program or detox ☐ methadone ☐ buprenorphine (Suboxone) ☐ incarcerated

☐ on parole, probation ☐ Other (*explain*): _____

Please complete this chart for all opiates you have used.

Name of drug	**Route(s) of use** **oral, snort, smoke, inject**	**How much used**	**Dates used**	**Prescribed?** **Yes / No**	**Used in past 30 days?** **Yes / No**

Opioid Dependence Treatment History

Dates	**Type of treatment** **methadone, buprenorphine, counseling, residential, other**	**Where did you receive treatment?**	**Why did you leave treatment?**	**How long did you remain drug-free after you left treatment?**

Current Use

Current opioid(s) used: _____

☐ Oral (*by mouth*) ☐ Snort ☐ Smoke ☐ Inject

How much do you use every day? _____

How many times a day do you use? _____

When did you last use? Date: _____ Amount: _____

Are you in withdrawal now? Yes / No

If yes, what withdrawal symptoms do you have? Check the symptoms.

( ) general discomfort	( ) diarrhea	( ) headache
( ) hot / cold	( ) runny nose	( ) weakness
( ) sweats	( ) watery eyes	( ) anxiety, irritability
( ) goosebumps	( ) sneezing	( ) restlessness, agitation
( ) stomachache	( ) yawning	( ) tremors, shakes
( ) nausea	( ) muscle aches, cramps	( ) sleep problems
( ) vomiting	( ) bone, joint aches	( ) cravings
( ) other:	( ) other:	( ) other:

If 1 means "I feel fine" and 10 means "I have the worst withdrawal ever," rate how you feel right now on a scale of 1 – 10 (*circle a number*):

1 2 3 4 5 6 7 8 9 10

I'm fine A little sick Moderately sick Very sick Worst ever

Other Substance Use History

Check the appropriate boxes on the following chart.

	No (Never used)	**If yes, age at first use**	**How did you take it?**	**How much?**	**How often?**	**Date of last use**	**Quantity last used**
Alcohol							
Caffeine (pills or beverages)							
Cocaine							
Crystal Meth-Amphetamine							

Inhalants							
LSD or Hallucinogens							
Marijuana							
PCP							
Stimulants (pills)							
Sedatives or Sleeping Pills							
Ecstasy							
Chewing tobacco							
Cigarettes							
Cigars							
Other:							
Other:							

Comments (*inpatient, detox, rehabilitation centers, outpatient IOPs, etc*.):

_____

_____

_____

Current or Past Medical Conditions (*check all that apply*)

( ) high blood pressure	( ) stroke, neurologic disorder	( ) thyroid problems
( ) diabetes	( ) stomach, intestinal problems	( ) arthritis
( ) heart disease	( ) pancreas problems	( ) chronic pain
( ) high cholesterol, lipid disorder	( ) kidney problems	( ) cancer Type:
( ) seizure disorder, epilepsy	( ) lung disease (asthma, COPD)	( ) nutritional problems

Hepatitis: Have you ever been tested for **Hepatitis C**? Yes / No When? _____
Result: _____

Have you ever had **Hepatitis A**? Yes / No When? _____

Have you ever had **Hepatitis B**? Yes / No When? _____

Have you been vaccinated against Hepatitis A or Hepatitis B? Yes / No

When? _____

HIV: Have you been tested for HIV? Yes / No When was your last test? _____
Result: _____

TB: When was your last TB skin test? _____

Have you ever tested positive for TB? Yes / No If yes, when? _____

STDs: □ Syphilis □ Gonorrhea □ Herpes □ Chlamydia □ Other: _____

Do you use condoms? Yes / No

Do you have tattoos? Yes / No

Do you have body piercings? Yes / No

Have you ever had surgery or been hospitalized overnight? Yes / No
If yes, please describe and list dates:

_____

_____

_____

Have you ever experienced physical trauma, such as bone fractures or accidents? Yes / No
If yes, please describe and list dates:

_____

_____

_____

To your knowledge, have you had all required and recommended vaccinations? Yes / No

Please list any allergies you have (*medications, bees, peanuts, environmental*):

_____

_____

_____

Current prescribed medications (*list medication, dose, and frequency*):

_____

_____

_____

_____

_____

_____

Describe any medical, psychiatric, or drug and alcohol use that runs in your family.

_____

_____

_____

_____

_____

_____

Women's Reproductive History

Have you ever been pregnant? Yes / No If yes, how many children have you had? _____

Their ages: _____

Have you had any miscarriages? Yes / No If yes, how many? _____

Have you had any abortions? Yes / No If yes, how many? _____

Date of last menstrual period: _____

Date of last gynecological exam: _____

Date of last mammogram: _____

Do you use birth control now? Yes / No If yes, what kind? _____

Comments: _____

_____

Male Reproductive History

Do you have children? Yes / No If yes, how many children have you had? _____

Their ages: _____

Do you use birth control? Yes / No If yes, what kind? _____

Comments:

_____

_____

Psychiatric History

Have you ever been diagnosed or treated for any psychiatric disorder? If yes, check off and explain.

☐ Depression _____

☐ Anxiety _____

☐ Bipolar Disorder

_____

☐ Schizophrenia _____

☐ ADHD _____

☐ Schizoaffective disorder _____

☐ Eating disorder_____

☐ Cutting/self-mutilation _____

☐ Learning disability _____

☐ Personality disorder_____

☐ Ever thought about hurting yourself? Yes / No

☐ Ever tried to hurt yourself? Yes / No When? _____

☐ Other: _____

If you have never been diagnosed or treated for any of the above, do you think you may have a diagnosis?

Yes / No Explain: _____

Current prescribed psychiatric medications (*include name, dose, how often you take it*):

_____

_____

_____

_____

_____

_____

List any previously prescribed psychiatric medications:

_____

_____

_____

List any prior hospitalizations for psychiatric conditions:

_____

_____

_____

Recent Stressful Events

- ☐ married
- ☐ engaged
- ☐ separated
- ☐ divorced
- ☐ breakup of important relationship
- ☐ legal problems
- ☐ personal injury or illness
- ☐ difficulties or changes at school or work
- ☐ moved or changed residence
- ☐ pregnancy
- ☐ birth of child
- ☐ child left home
- ☐ death of a loved one
- ☐ loved one's medical problems
- ☐ behavior problems in family member
- ☐ sexual problems
- ☐ retired or lost job
- ☐ foreclosure

□ financial problems □ other: _____

Notes: _____

_____

What are your goals and expectations for treatment/services?

_____

_____

_____

_____

_____

_____

_____

Any other information you would like to share?

_____

_____

_____

_____

_____

_____

Signature: _____

Print name: _____

Date: _____