

BUPRENORPHINE MAINTENANCE TREATMENT

INTAKE QUESTIONNAIRE FOR PATIENT TREATMENT-PLANNING QUESTIONS

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 YOU FOR
CLINIC VISITS?

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

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

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

WHAT ARE YOUR REASONS FOR BEING INTERESTED IN
BUPRENORPHINE TREATMENT?

WHEN WAS THE LAST TIME YOU RELAPSED TO DRUG ABUSE? _____

WHAT 'TRIGGERS' DO YOU KNOW WHICH HAVE PUT YOU IN DANGER OF
RELAPSE IN THE PAST, OR WHICH MIGHT IN THE FUTURE?

WHAT COPING METHODS HAVE YOU DEVELOPED TO DEAL WITH THESE
TRIGGERS TO RELAPSE?

WHAT PLANS DO YOU HAVE FOR THE COMING YEAR?

WORK? _____

HOME? _____

OTHER? _____

WHAT MEDICAL CARE WILL YOU HAVE IN THE COMING YEAR?

HOW WILL YOU COMPLY WITH THE ANNUAL EXAMINATION AND LABORATORY AND TB TESTING REQUIREMENTS? _____

WHAT KINDS OF HELP WOULD YOU LIKE FROM YOUR CLINIC COUNSELOR? _____

WHAT ARE YOUR STRENGTHS AND SKILLS TO HANDLE TAKE-HOME BUPRENORPHINE?

WHAT WORRIES DO YOU HAVE ABOUT EXTENDED TAKE-HOMES?

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

WHAT ARE THE MAJOR SOURCES OF STRESS IN YOUR LIFE ?
