PATIENT INTAKE: MEDICAL HISTORY

Name		
Address		
Phone (W)	(H)(C	C)
DOB	Age SS#	
Emergency Contact		
Relationship to patient_	Phone_	
Primary care physician_	Phone_	
Have you ever had an El	KG? Y N Date	_
Current or past medical	conditions (check all that apply)	
() Asthma/respiratory	() Cardiovascular (heart attack, l	high cholesterol, angina)
() Hypertension	() Epilepsy or seizure disorder	() GI disease
() Head trauma	() HIV/AIDS	() Diabetes
() Liver problems	() Pancreatic problems	() Thyroid disease
() STDs	() Abnormal Pap smear	() Nutritional Deficiency
Other (Please Describe)		
If there is a family history that illness.	of any of the illnesses listed above, pl	ease put an "F" next to
MD NOTES		

Is there a family history of anything NOT listed here? (Please explain)
MD NOTES
Have you ever had surgery or been hospitalized? (Please describe)
MD NOTES
Childhood Illnesses Measles Y N Mumps Y N Chicken Pox Y N Have you or a family member ever been diagnosed with a psychiatric or mental illness? (Please describe)
Have you ever taken or been prescribed antidepressants ? () N If yes, for what reason
Medication(s) and dates of use
Why stopped
Please list all current prescription medications and how often you take them (example: Dilantin 3x/day). DO NOT include medications you may be currently misusing (that information is needed later).

Please list all current herbal medicines , take them	vitamin supplements, etc. and how often you
MD NOTES	
Please list any allergies you have (penic	illin, bees, peanuts)
MD NOTES	
Tobacco History	
Cigarettes: Now? Y N	In the past? Y N
How many per day on average?	For how many years?
Pipe: Now? Y N	In the past? Y N
How often per day on average?	For how many years?
Have you ever been treated for substar where and for how long)	nce misuse? () N (Please describe when,
Have you ever been treated for substar	
How long have you been using substan	ces?

Substance Use History

	No	Yes/Past or Yes/Now	Route	How Much	How Often	Date/Time of Last Use	Quantity Last Used
Alcohol		1 0 0 1 1 0 1 1		MINCH	Oitti		
Caffeine (pills or beverages)							
Cocaine							
Crystal Meth- Amphetamine							
Heroin							
LSD or Hallucinogens Marijuana							
Methadone							
Pain Killers							
PCP							
Stimulants (pills)							
Tranquilizers/ Sleeping Pills							
Ecstasy							
Inhalants							
Other							
Oid you ever sto	p using	any of the ab	ove becaus	se of depend	dence? ()	N (Please list)	

MD NOTES			
-			
-			

PATIENT INTAKE: SOCIAL/FAMILY HISTORY

(Circle one)	Married	Single	Long-term relationsl	nip Divorced/Separated
Years married/in	long-term relati	ionship	Times Married	Times Divorced
Children () N	() Y Cur	rrent ages (list)		
Residing with yo	u? () N ()	Y If no, who	ere?	
Where are you cu	urrently living?			
Do you have fam	ily nearby? ()	N (Please de	escribe)	
Education (check () Graduate Sc			e () Profession	onal or Vocational School
() High School	l	Grade		
Are you currently	y employed? () N Where	(if "no" where were you	last employed?)
What type of wor	rk do/did you do	0?		
How long have/d	id you work(ed)) there?		
Have you ever be () DWI/DUI			N Domestic violence	() Other
Have you ever be () Physically () Emotionally	() Sexuall		ape or attempted rape)	() Verbally
	() Past	` '	Current () Past Current () Past	CA () Current () Past
If you are not cur	rently attending	meetings, who	at factors led you to stop	5?
Have you ever be	een in counseling	g of therapy?	() N (Please describe)

PATIENT TREATMENT CONTRACT

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 no 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 other 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.

	, ,	
	Date	
Patient Signature		
	Date	
Physician Signature		

15. I understand that violations of the above may be grounds for termination of treatment.

EXPLANATION OF TREATMENT

Intake

You will be given a comprehensive substance dependence assessment, as well as an evaluation of mental status and physical exam. The pros and cons of the medication, SUBOXONE, will be presented. Treatment expectations, as well as issues involved with maintenance versus medially supervised withdrawal will be discussed.

Induction

You will be switched from you current opioid (heroin, methadone, or prescription painkillers) on to SUBOXONE. At the time of induction, you will be asked to provide a urine sample to confirm the presence of opioids and possible other drugs. You must arrive for the first visit experience mild to moderate opioid withdrawal symptoms. Arrangements will be made for you to receive your first dose shortly after your initial appointment. Your response to the initial dose will be monitored. You may receive additional medication, if necessary, to reduce your withdrawal symptoms.

Since an individual's tolerance and reaction to SUBOXONE vary, daily appointments may be scheduled and medications will be adjusted until you no longer experience withdrawal symptoms or cravings. Urine drug screening is typically required for all patients at every visit during this phase.

Intake and Induction may both occur at the first visit, depending on your needs and your doctor's evaluation.

Stabilization

Once the appropriate dose of SUBOXONE is established, you will stay at this dose until steady blood levels are achieved. You and your doctor will discuss your treatment options form this point forward.

Maintenance

Treatment compliance and progress with be monitored. Participation in some form of behavioral counseling is strongly recommended to ensure best chance of treatment success. You are likely to have scheduled appointments on a weekly basis, however, if treatment progress is good and goals are met, monthly visits will eventually be considered sufficient. The Maintenance phase canals from weeks to years-the length of treatment will be determined by you and your doctor, and, possibly, your counselor. Your length of treatment may vary depending on your individual needs.

Medically Supervised Withdrawal

As your treatment progresses, you and your doctor may eventually decide that medically supervised withdrawal is an appropriate option for you. In this phase, your doctor will gradually taper your SUBOXONE dose over time, taking care to see that you do not experience any withdrawal symptoms or cravings.

EXPLANATION OF 1ST VISIT—No In-Office Supply

Your first visit is generally the longest, and may last anywhere from 1 to 4 hours.

When preparing for your 1st office visit, there are a couple of logistical issues you may want to consider.

- You may not want to return to work after your visit-this is very normal, so just plan accordingly.
- Because SUBOXONE can cause drowsiness and slow reaction times, particularly during the 1st few weeks of treatment, driving yourself home after the 1st visit is generally not recommended, so you may want to make arrangements for a ride home.

It is very important to arrive for your 1st visit already experiencing mild to moderate opioid withdrawal symptoms. If you are in withdrawal, buprenorphine will help lessen the symptoms. However, if you are not in withdrawal, buprenorphine will "override" the opioids already in your system, which will cause severe withdrawal symptoms.

The following guidelines are provided to ensure you are in withdrawal for the visit. (If this concerns you, it may help to schedule your first visit in the morning: some patients find it easiest to skip what would normally be their first dose of the day).

- No methadone or long-acting painkillers for at least 24 hours.
- No heroin or short-acting painkillers for at least 4 to 6 hours.

Bring ALL medication bottles with you to your 1st appointment.

Before you can be seen by the doctor, all of your paperwork must be completed, so bring all your completed forms with you or arrive about 30 minutes early. In addition, you will need to pay the doctor's fees prior to treatment.

Urine drug screening is a regular feature of SUBOXONE therapy, because it provides physicians with important insights into your health and your treatment. Your 1st visit will include urine drug screening, and may also entail a Breathalyzer ® test and blood work. If you haven't had a recent physical exam, your doctor may require one. To help ensure that SUBOXONE is the best treatment option for you, your doctor will perform a substance dependence assessment and mental status evaluation. Lastly, you and your doctor will discuss SUBOXONE and your expectations of treatment.

After this portion of your visit is completed, your doctor will give you a SUBOXONE prescription. You fill the prescription at the pharmacy and return to the doctor's office so you can take the medication in a safe place where the medical staff can monitor your response.

Your response to the medication will be evaluated after 1 hour and possibly again after 2 hours. Once the doctor is comfortable with your response, you can schedule your next visit and go home. Your doctor may ask you to keep a record of any medications you take at home to control withdrawal symptoms. You will also receive instructions on how to contact your doctor in emergency, as well as additional information about treatment.

CHECKLIST FOR 1st VISIT:

Ш	Arrive experiencing mild to moderate opioid withdrawal symptoms
	Arrive with a full bladder
	Bring completed forms
	Bring ALL medication bottles
	Fees due at time of visit (cash, check or credit card)