



3500 LaTouche Street, Suite 240A | Anchorage, AK 99508 | Phone (907) 276-4611 | FAX (907) 258-5167

New Patient OUD Questionnaire

Name _____ Date _____

What brings you to treatment today? _____

Which pharmacy will you be using? _____

Primary Care Provider? Yes No Name of PCP: _____

Marital Status: Single Separated Divorced Married Widowed

Do you have children? Yes No **If yes, do they live with you?** Yes No

Their ages are: _____

Personal & Family Health History *(Please check-mark each item you or a family member has been diagnosed with.)*

	<u>Self</u>	<u>Family</u>		<u>Self</u>	<u>Family</u>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	COPD/Emphysema	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B or C	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Headaches/Migraine	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Bowel Disorders	<input type="checkbox"/>	<input type="checkbox"/>

Please list all hospitalizations and surgeries you have ever had:

Surgery	Year	Hospital

Allergies

What are you allergic to?	What was your reaction?	Do you require treatment?

Current Medications and Supplements

Please list ALL prescriptions and over-the-counter (OTC) medications or supplements you are CURRENTLY taking, including ALL pain medication. If you need more space, please attach an additional page to the packet.

Name of Medication/Supplement/Ointment	Strength	How often each day?

GOALS in RECOVERY

Please list 3 very specific and measurable goals for things you would like to do, and would return to doing, if your addiction were more manageable.

Specific activity/goal:	How many/often?	By what date?

Nicotine Use

Do you use nicotine? Yes No If yes, what form? _____

Average daily amount: _____ Would you like help quitting now? Yes No

If not, would you be interested in quitting at some time in the future? Yes No

Quality of Sleep Good Fair Poor Number of hours nightly? _____

Do you suffer from insomnia? Yes No

Are you diagnosed with sleep apnea? Yes No Do you use CPAP/BiPAP? Yes No

Any chest pain since last visit? Yes No Shortness of breath or difficulty breathing? Yes No

Any medical issues that you would like me to evaluate today? Yes No

Would you like urine testing for chlamydia or gonorrhea today? Yes No

Any other labs or testing you would like to request today? Yes No

Do you have any thoughts of suicide or of wanting to hurt yourself or others? Yes No

If yes, do you have a plan? Yes No If yes, please describe _____

Have you ever attempted suicide in the past? Yes No If yes, when and what method did you use? _____

Mental Health Treatment History

Please **check-mark** any of the following issues **you have now or have had in the past.**

- | | | | |
|--------------------------------------------|----------------------------------------------|------------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Suicidal thoughts | <input type="checkbox"/> Homicidal thoughts | <input type="checkbox"/> PTSD | <input type="checkbox"/> ADD/ADHD |
| <input type="checkbox"/> Hearing voices | <input type="checkbox"/> Anger | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> OCD | <input type="checkbox"/> Depression | <input type="checkbox"/> Hallucinations |
| <input type="checkbox"/> Changes in mood | <input type="checkbox"/> Difficulty sleeping | <input type="checkbox"/> Personality Disorders | <input type="checkbox"/> Schizophrenia |
| <input type="checkbox"/> Schizophrenia | <input type="checkbox"/> Bi-polar disorder | <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Eating Disorders |

Counseling for Mental Health/Psychiatric Issues:

Please check-mark any type of counseling you are currently engaged in or have tried in the past.

Please include name(s) of clinic/clinician and year(s) of participation.

- 1:1 Psychiatric Counseling If yes, with whom? _____ Year(s)? _____
- Group Counseling If yes, with whom? _____ Year(s)? _____
- In-patient Psychiatric Care If yes, with whom? _____ Year(s)? _____
- Spiritual Leader If yes, with whom? _____ Year(s)? _____

Employment and Education

I am employed at _____ as a _____ for _____ hours/week.

I am unemployed. Yes No I have not been employed since: _____

Are you seeking work? Yes No Are you retired? Yes No

Are you receiving disability? Yes No If yes, since when? _____

What is your disability based on? _____

If you are NOT currently receiving disability, have you applied for disability? Yes No

If you have applied for disability, do you have an attorney? Yes No

Do have have any of the following: GED/H.S. Diploma Trade School Vocational Training
 Some College College Graduate Apprenticeship Training

Are you currently attending school, or a trade or vocational program? Yes No

If yes, part-time or full-time? Which program? _____

Are you interested in additional job training and/or academic education? Yes No

Sexual Health

Are you sexually active? Yes No

Are your sexual partners men women or both?

Have you recently tested positive for any STI's? Yes No

If yes, did you and your partner(s) receive appropriate treatment? Yes No

Do you have a primary care provider? Yes No Name: _____

When was the last time you saw your primary care provider? _____

Family Support

Do you have any family members **who misuse** medications, illicit drugs or alcohol? Yes No

If yes, do they live nearby? Yes No

Do you have any family members who are **NOT** suffering from addiction? Yes No

If yes, do they live nearby? Yes No Are they supportive of your recovery efforts? Yes No

Peer Support

What kinds of "clean" peer support for recovery do you have? friends Co-workers

Do you have friends and/or co-workers who are suffering from addiction? Yes No

Are there people in your home who misuse medication, illicit substances or alcohol? Yes No

What is your plan for staying in recovery while others around you are actively using?

Are you prepared to seek relationships with new, non-using friends? Yes No

Housing and Financial Status

Housing Situation: Live alone Live w/spouse or SO Live w/children Roommate

Live w/other family Shared Housing Couch surfing Homeless Staying in a Shelter

Do you: Rent Own your home

Do you feel safe in your home environment? Yes No

Financial Status: Do you feel financially stable? Yes No

What is your main source of income? _____

Do you need or want help accessing local services for housing, food or other assistance? Yes No

Are you familiar with the local 2-1-1 phone number for help accessing services? Yes No

Legal Issues

Do you have any legal issues pending? Yes No **If yes,** are you on supervision? Yes No

If yes, is there someone you would like us to communicate with on your behalf? Yes No

If yes, please provide phone # and name/title: _____

Please state the nature of the charges _____

Are you facing incarceration in the future? Yes No Ankle monitor? Yes No

Are you on 3rd party supervision? Yes No

Have you ever been arrested for selling or distributing drugs? Yes No

Substance Use and Chemical Dependency Treatment History

What substances do you feel you are dependent on/addicted to? _____

How severe do you feel your addiction is? Mild Moderate Severe

At what age do you feel you may have developed a drug or alcohol problem? _____

Have you ever obtained pain or other prescription medication other than from a provider? Yes No

Have you ever experienced a drug overdose? Yes No If yes, when? _____

What substance(s) did you overdose on? _____

Has Narcan ever been administered to you? Yes No

Do you have your own supply of Narcan? Yes No **If not, please ASK!**

Do family and friends also have their own supply of Narcan? Yes No **If not, please ASK!**

Please list ALL the substances you have used in the last 90 days:

Substance Use History

Opioids (including codeine, heroin, morphine, methadone, fentanyl, oxycodone, hydrocodone, oxymorphone, meperidine, propoxyphene or other)

1.	Past or present?	Route?
Age of first use?	Last use?	Average daily amount?

2.	Past or present?	Route?
Age of first use?	Last use?	Average daily amount?

3.	Past or present?	Route?
Age of first use?	Last use?	Average daily amount?

Benzodiazepines (including alprazolam - Xanax, diazepam - Valium, clonazepam - Klonopin, oxazepam - Serax, chlordiazepoxide - Librium or other)

1.	Past or present?	Route?
Age of first use?	Last use?	Average daily amount?

Barbiturates (Seconal, phenobarbital, Dalmane, Restoril or other)

1.	Past or present?	Route?
Age of first use?	Last use?	Average daily amount?

Stimulants (Methamphetamine, cocaine, amphetamines, methylphenidate or other)

1.	Past or present?	Route?
Age of first use?	Last use?	Average daily amount?

2.	Past or present?	Route?
Age of first use?	Last use?	Average daily amount?

Marijuana/Spice (Marijuana, spice, bath salts, synthetic marijuana or other)

1.	Past or present?	Route?
Age of first use?	Last use?	Average daily amount?

Inhalants (glue, markers, anesthetics, propane, paint thinner, gasoline, lighter fluid or other)

1.	Past or present?	Route?
Age of first use?	Last use?	Average daily amount?

Hallucinogens (MDMA - ecstasy, GHB, rohypnol, ketamine, LSD - acid or other)

1.	Past or present?	Route?
Age of first use?	Last use?	Average daily amount?

Misc. (Kratom, gabapentin, Lyrica)

1.	Past or present?	Route?
Age of first use?	Last use?	Average daily amount?

Alcohol

Type?	Past or present?	Route?
Age of first use?	Last use?	Average daily amount?

Chemical Dependency Treatment

Please check-mark any type of addiction treatment you are currently engaged in or have tried in the past. Please include name(s) of clinic/clinician and year(s) of participation.

- Outpatient Treatment If yes, where? _____ Year(s)? _____
- Intensive Outpatient If yes, where? _____ Year(s)? _____
- In-patient Treatment If yes, where? _____ Year(s)? _____
- Methadone Maintenance Program (OTP) If yes, where? _____ Year(s)? _____
- Suboxone, Vivitrol or Sublocade (MAT) If yes, where? _____ Year(s)? _____
- Other kind of treatment? If yes, where? _____ Year(s)? _____

What kinds of support groups do you participate in within the community?

- 12-step Groups (AA/NA, etc) Celebrate Recovery Alano Club Other: _____
- Church-sponsored Recovery Group

What would you say your biggest loss or regret in life is due to addiction?

Stop Bang Questionnaire

1. Do you snore loudly? (Louder than talking or loud enough to be heard through closed doors) Yes No
2. Do you often feel tired, fatigued, or sleepy during the daytime? Yes No
3. Has anyone observed you stop breathing during sleep? Yes No
4. Do you have (or are you being treated for) high blood pressure? Yes No
5. Age: _____
6. Gender: Male Female Neck Circumference: (MA will measure) _____

Generalized Anxiety Disorder (GAD-7) Questionnaire

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Not being able to stop or control worrying.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Worrying too much about different things.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Trouble relaxing.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Being so restless that it's hard to sit still.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Becoming easily annoyed or irritable.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Feeling afraid as if something awful might happen.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	XXXXXX			
Total Score	XXXXXX	XXXXXX	XXXXXX	

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____ Somewhat difficult _____ Very difficult _____ Extremely difficult _____

Patient Health Questionnaire (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (circle your response)	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Feeling down, depressed, or hopeless.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Trouble falling or staying asleep, or sleeping too much.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Feeling tired or having little energy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Poor appetite or overeating.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Feeling bad about yourself, or that you are a failure or have let yourself or your family down.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Trouble concentrating on things, such as reading the newspaper or watching television.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Moving or speaking so slowly that other people could have noticed. Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Thoughts that you would be better off dead, or of hurting yourself.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	XXXXX			
Total	XXXXX	XXXXX	XXXXX	

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all ____ Somewhat difficult ____ Very difficult ____ Extremely difficult ____

DSM-5 Criteria for Diagnosis of Opioid Use Disorder

Check all that apply

<input type="checkbox"/>	Opioids are often taken in larger amounts or over a longer period of time than intended.
<input type="checkbox"/>	There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
<input type="checkbox"/>	A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.
<input type="checkbox"/>	Craving, or a strong desire to use opioids.
<input type="checkbox"/>	Recurrent opioid use resulting in failure to fulfill major role obligations at work, school or home.
<input type="checkbox"/>	Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.
<input type="checkbox"/>	Important social, occupational or recreational activities are given up or reduced because of opioid use.
<input type="checkbox"/>	Recurrent opioid use in situations in which it is physically hazardous.
<input type="checkbox"/>	Continued use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by opioids.
<input type="checkbox"/>	*Tolerance, as defined by either of the following: a) A need for markedly increased amounts of opioids to achieve intoxication or desired effect. b) Markedly diminished effect with continued use of the same amount of an opioid.
<input type="checkbox"/>	*Withdrawal, as manifested by either of the following: a) The characteristic opioid withdrawal syndrome. b) The same (or a closely related) substance are taken to relieve or avoid withdrawal symptoms.

Subjective Opiate Withdrawal Scale (SOWS)

Please write in a number from 0 - 4 corresponding to how you feel about each symptom RIGHT NOW
(Scale: 0 = not at all, 1 = a little, 2 = moderately, 3 = quite a bit, 4 = extremely)

	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6
I feel like using now.						
I feel anxious.						
I feel like yawning.						
I am perspiring.						
My eyes are teary.						
My nose is running.						
I have goosebumps.						
I am shaking.						
I have hot flushes.						
I have cold flashes.						
My bones and muscles ache.						
I feel restless.						
I feel nauseous.						
I feel like vomiting.						
My muscles twitch.						
I have stomach cramps.						
TOTAL						

It is recommended that you be in moderate withdrawal, and that it has been at least 12-24 hours since your last use of a short-acting opioid such as percocet or heroin, before taking your first dose of Suboxone (or any buprenorphine product). It is recommended that you wait 24-72 hours or longer for long-acting opioids such as OxyContin or MS Contin. If you are taking methadone, you need to get your daily dose down to 30 mg/day or less for at least two weeks, and it may be necessary to wait 7-28 days before beginning Suboxone (or any buprenorphine) to avoid experiencing precipitated withdrawal.

REVIEW OF SYSTEMS (Check the box of all symptoms you have been experiencing since your last visit.)

Constitutional:

- Fatigue
- Restlessness
- Fever
- Chills
- Hot flashes
- Cold flushes
- Increased appetite
- Decreased appetite
- Weight gain
- Weight loss
- Night sweats

Skin:

- Rash
- Hives
- Sweating
- Excessive itching
- Moles changing size, shape or color
- Sores
- Goosebumps
- Blisters
- Painful lesions

HEENT:

- Nasal congestion
- Runny nose
- Sore throat
- Loss of teeth
- Dentures
- Cavities/gum disease
- Dry mouth
- Loss of taste
- Loss of smell
- Yawning
- Watery eyes
- Visual changes
- Ringing in ears
- Hearing loss

Cardiovascular:

- Chest pain
- Heart racing
- Lightheaded
- Palpitations
- High blood pressure
- Swollen ankles or legs

Respiratory:

- Shortness of breath
- Cough
- COPD/emphysema
- Wheezing
- Sleep Apnea

Musculoskeletal:

- Twitching
- Weakness
- Shaking
- General body aches
- Joint swelling
- Morning stiffness
- Bone aches
- Cramps
- Muscle aches
- Joint pain
- Joint redness

Genitourinary:

- Difficulty urinating
- Blood in urine
- Pain w/urination
- Leaky bladder
- Loss of bladder control

If female: Are you pregnant? Yes No

Date of last cycle: _____

Please notify us immediately if you become pregnant.

Gastrointestinal:

- Nausea
- Diarrhea
- Heartburn
- Stomach cramps
- Loss of bowel control
- Abdominal pain, cramping or distension
- Vomiting
- Constipation
- Red blood in stool
- Black, tarry stool
- Yellow eyes or skin

Bowel Movements are:

- Daily
- Every other day
- 2x/week
- Every 5-6 days
- Once weekly

Is this your normal frequency? Yes No

Is this LESS or MORE frequent than normal?

Neurological:

- Tremors
- Tingling
- Fainting
- Frequent falls
- Numbness
- Headache
- Seizures
- Involuntary movements

Endocrine:

- Diabetes
- Excessive thirst
- Heat/Cold Intolerance
- Thyroid Issues
- Low libido

Hematologic/Lymphatic:

- Abnormal bleeding
- Swollen lymph nodes
- Anemia
- Bleeding disorder
- Bruising easily
- Lymphedema
- Clotting disorder

Immunologic/Allergic:

- Asthma
- Current cold
- Seasonal allergies
- Current flu

Psychiatric

- Suicidal thoughts
- Anxiety
- Depression
- Craving drugs
- Bi-polar disorder
- PTSD
- Hearing voices
- Irritability
- Changes in mood
- Homicidal thoughts
- Hallucinations
- Schizophrenia
- Panic attacks
- ADD/ADHD
- Anger issues
- OCD
- Difficulty sleeping