Fireweed Health Care, Inc.

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New Patient OUD Questionnaire

Name_____ **Date**_____

How did you hear about us? _____

What brings you to treatment today? _____

_____

Past Medical and Family History *(Please check-mark each item you or a family member has been diagnosed with.)*

	Self	Family		Self	Family
Arrhythmia/murmur	▢	▢	Sleep Apnea	▢	▢
Heart Disease	▢	▢	Asthma	▢	▢
High Blood Pressure	▢	▢	COPD/Emphysema	▢	▢
Heart Attack	▢	▢	Osteoporosis	▢	▢
Stroke	▢	▢	Hepatitis B or C	▢	▢
Seizures	▢	▢	Liver Disease	▢	▢
Diabetes	▢	▢	Headaches/Migraine	▢	▢
Thyroid Disease	▢	▢	Anemia	▢	▢
Kidney Disease	▢	▢	Bowel Disorders	▢	▢
Cancer: _____	▢	▢	Traumatic Brain Injury	▢	▢
Sickle Cell Disease	▢	▢	Clotting Disorder	▢	▢
Arthritis	▢	▢	Fibromyalgia	▢	▢
HIV/Aids	▢	▢	Osteomyelitis	▢	▢
Endocarditis	▢	▢	MRSA	▢	▢
Syphilis	▢	▢	Tuberculosis	▢	▢
Hysterectomy	▢	▢	Tubal Ligation	▢	▢
IUD	▢	▢	Nexplanon	▢	▢
Condoms	▢	▢			

Please list all SURGERIES and HOSPITALIZATIONS:

Reason for surgery or hospitalization	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?**

Which pharmacy will you be using? _____

Nicotine, Caffeine and Alcohol Use

Do you use nicotine? ▢ Yes ▢ No If yes, what form? _____
Average daily amount: _____ Would you like help quitting now? ▢ Yes ▢ No
If no, would you be interested in quitting at some time in the future? ▢ Yes ▢ No

Do you consume any caffeine? ▢ Yes ▢ No
If yes, in what? ▢ Coffee ▢ tea ▢ soda ▢ diet soda ▢ energy drinks ▢ _____

Do you consume any alcohol? ▢ Yes ▢ No If yes, when did you last drink alcohol? _____
How often do you drink? ▢ Most days ▢ Weekly ▢ Monthly ▢ Special occasions ▢ _____
What kind of alcohol do you consume? ▢ Beer ▢ Wine ▢ Wine coolers ▢ Liquor

** Due to the significant risks of sedation, respiratory depression, coma, seizure and/or death when consuming alcohol if being prescribed Suboxone or consuming any other central nervous system depressants, anxiolytics, sedative/hypnotics or other similar substances, no alcohol can be consumed if receiving any such agents while in our program. Please sign your name below to acknowledge this expectation and to agree to this condition of treatment. We also offer treatment for alcohol use disorder and to help you succeed in your recovery goals.*

Name_____ Date_____

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

Employment, Volunteering or other Participation
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 volunteering in the community? ▢ Yes ▢ No If yes, how many hours/week? _____
Are you raising children or grandchildren full-time? ▢ Yes ▢ No
Are you a full-time caregiver for a family member? ▢ 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

Are you retired? ▢ Yes ▢ No If yes, do you have an active hobby? ▢ Yes ▢ No
If you have an active hobby, what is it? _____

Do have have any of the following: ▢ GED/H.S.I 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

Mental Health Treatment History

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

▢ Suicidal thoughts	▢ Homicidal thoughts	▢ PTSD	▢ ADD/ADHD
▢ Hearing voices	▢ Anger	▢ Anxiety	▢ Irritability
▢ Irritability	▢ OCD	▢ Depression	▢ Hallucinations
▢ Changes in mood	▢ Difficulty sleeping	▢ Personality Disorders	▢ Schizophrenia
▢ Schizophrenia	▢ Bi-polar disorder	▢ Panic attacks	▢ Eating Disorders

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, please state when and what method you used. _____

_____

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)? _____
▢ Other: _____

Social History and Support

Marital Status and Housing Situation

Are you: ▢ Single ▢ Separated ▢ Divorced ▢ Married ▢ Widowed

Who do you live with? ▢ Lives alone ▢ Lives w/spouse or SO ▢ Lives w/children ▢ Roommate ▢ Lives w/other family ▢ Shared Housing ▢ Couch surfing ▢ Homeless ▢ Staying in a Shelter

Do you: ▢ Rent an apartment or home ▢ Own your home

Do you feel your housing situation is stable? ▢ Yes ▢ No

Do you feel safe in your home environment? ▢ Yes ▢ No

Do you have children? ▢ Yes ▢ No How many? _____ Do they live with you? ▢ Yes ▢ No

Their ages are: _____

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 who support you in recovery? ▢ Yes ▢ No

If yes, do they live nearby? ▢ 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

Financial Status

Do you feel financially stable? ▢ Yes ▢ No

What is your main source of income? _____

Are you receiving any financial assistance from ▢ others or the ▢ government? ▢ Yes ▢ No

Do you need or want help accessing local services? ▢ 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 Wearing ankle monitor? ▢ Yes ▢ No

Are you on 3rd party supervision? ▢ Yes ▢ No

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

If yes, please explain when and where you were charged. _____

_____

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?

Alcohol (including beer, wine coolers, wine, hard liquor and route - oral, nasal, rectal, injection)

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?

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?

2.	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?

2.	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?

2.	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?

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

Tobacco/Nicotine (cigarettes, cigars, vaping, smokeless tobacco or other)

1.	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)? _____
▢ If more than once, about how many times? _____

▢ Intensive Outpatient If yes, where? _____ Year(s)? _____
▢ If more than once, about how many times? _____

▢ In-patient Treatment If yes, where? _____ Year(s)? _____
▢ If more than once, about how many times? _____

▢ Methadone Maintenance Program (OTP) If yes, where? _____ Year(s)? _____
▢ If more than once, about how many times? _____

▢ Suboxone, Vivitrol or Sublocade (MAT) If yes, where? _____ Year(s)? _____
▢ If more than once, about how many times? _____

▢ 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

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.	▢	▢	▢	▢
2. Not being able to stop or control worrying.	▢	▢	▢	▢
3. Worrying too much about different things.	▢	▢	▢	▢
4. Trouble relaxing.	▢	▢	▢	▢
5. Being so restless that it's hard to sit still.	▢	▢	▢	▢
6. Becoming easily annoyed or irritable.	▢	▢	▢	▢
7. Feeling afraid as if something awful might happen.	▢	▢	▢	▢
	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.	▢	▢	▢	▢
2. Feeling down, depressed, or hopeless.	▢	▢	▢	▢
3. Trouble falling or staying asleep, or sleeping too much.	▢	▢	▢	▢
4. Feeling tired or having little energy.	▢	▢	▢	▢
5. Poor appetite or overeating.	▢	▢	▢	▢
6. Feeling bad about yourself, or that you are a failure or have let yourself or your family down.	▢	▢	▢	▢
7. Trouble concentrating on things, such as reading the newspaper or watching television.	▢	▢	▢	▢
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.	▢	▢	▢	▢
9. Thoughts that you would be better off dead, or of hurting yourself.	▢	▢	▢	▢
	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

▢	Opioids are often taken in larger amounts or over a longer period of time than intended.
▢	There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
▢	A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.
▢	Craving, or a strong desire to use opioids.
▢	Recurrent opioid use resulting in failure to fulfill major role obligations at work, school or home.
▢	Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.
▢	Important social, occupational or recreational activities are given up or reduced because of opioid use.
▢	Recurrent opioid use in situations in which it is physically hazardous.
▢	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.
▢	*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.
▢	*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 ▢ Weakness
▢ Restlessness ▢ Increased appetite
▢ Fever ▢ Decreased appetite
▢ Chills ▢ Weight gain
▢ Weight loss ▢ Headache
▢ Cold flushes ▢ Hot flashes
▢ Night sweats

Skin:

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

HEENT:

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

Cardiovascular:

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

Respiratory:

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

Musculoskeletal:

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

Genitourinary:

▢ Difficulty urinating ▢ Leaky bladder
▢ Blood in urine ▢ 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 ▢ Vomiting
▢ Diarrhea ▢ Constipation
▢ Heartburn ▢ Red blood in stool
▢ Stomach cramps ▢ Black, tarry stool
▢ Loss of bowel control ▢ Yellow eyes or skin
▢ Abdominal pain, cramping or distension

Bowel Movements are:

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

Is this your normal frequency? ▢ Yes ▢ No
Is this ▢ LESS or ▢ MORE frequent than normal?

Neurological:

▢Tremors ▢ Numbness
▢Tingling ▢ Light headed
▢ Fainting ▢ Weakness
▢ Frequent falls ▢ Seizures
▢ Headache ▢ Involuntary movements

Endocrine:

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

Hematologic/Lymphatic:

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

Immunologic/Allergic:

▢ Asthma ▢ Seasonal allergies
▢ Current cold ▢ Current flu

Psychiatric

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