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INSTRUCTIONS: Please answer each question thoroughly. Write on the page or attach extra pages if additional space is needed. You may attach anything you feel is important for treating your addiction.

Today's Date _____

GENERAL INFORMATION:

Your First Name _____ MI _____ Your Last Name _____

Street Address _____ Town/City: _____ State _____ Zip _____

Phone Numbers Land-line (_____) _____ Cell (_____) _____

Your Date of Birth _____ Your Social Security # _____

Email address _____

INSURANCE / INSURER INFORMATION:

Policy Holder's name: _____ Circle: M or F

Relationship to patient: _____ Group #: _____
(self, spouse, child)

Insurance Co.: _____ Phone #: for benefits: _____

ID# of patient: _____ SS# of policyholder: _____

ID# of the policyholder (if different): _____ DOB of policyholder: _____

Secondary policy (ID #, Ins. Co. name, etc.) _____
(if applicable)

If your insurance requires an authorization to pay for your visits, please call your insurance to request an authorization and authorization number. Please note that some insurance companies no longer "backdate" authorizations; if your visits aren't authorized prior to your visit, the company will not pay!

Authorization #: _____ # of visits authorized: _____

Date started: _____ Date ends: _____

CONTACT INFORMATION:

Nearest Kin (to notify in case of emergency):

First Name _____ Last Name _____ Relation to you _____

Street Address _____ Town/City: _____ State _____ Zip _____

Phone Numbers Day (_____) _____ Evening (_____) _____

Your current *Medical Doctor*: First Name _____ Last Name: _____

Specialty (e.g. *psychiatry, internal medicine, family practice*) _____

Street Address _____ Town/City: _____ State _____ Zip _____

Phone Numbers Phone (_____) _____ Fax (_____) _____

Your *counselor/therapist* if you have one: First Name _____ Last Name: _____

Specialty (e.g. *psychiatrist, psychologist, social worker, substance abuse counselor*) _____

Agency/practice to which your counselor/therapist belongs _____

Street Address _____ Town/City: _____ State _____ Zip _____

Phone Numbers Phone (_____) _____ Fax (_____) _____

PATIENT INTAKE QUESTIONNAIRE:

Your preferred Name/Nickname if different from name above _____

F1. Marital status: Married Remarried Widowed Separated
 Divorced Never Married

NG3. Sexual orientation: Prefer not to say Heterosexual Homosexual Other

NG5. Are you actively involved in any religion? no yes

If yes, please explain _____

G6. Have you been in a controlled environment **in the past 30 days** where you were restricted from freely having access to alcohol or drugs? (Circle one of the following six choices).

1=NO 2=JAIL 3=ALCOHOL/DRUG TREATMENT 4=MEDICAL TREATMENT
5=PSYCHIATRIC TREATMENT 6=OTHER _____

G7. How many days (if any) have you been in a controlled environment? _____

M1. How many times **in your life** have you been hospitalized overnight for medical problems, *including* overdoses and “d.t.’s” (**do not include** hospitalizations for *other* drug or alcohol treatment, detoxification, psychiatric admissions or psychological problems, or admissions related to childbirth)

M5. Do you receive a pension, disability benefits, or “worker’s comp” for any *physical* disability (**do not include** payments received due to psychiatric or drug abuse disability). (Circle the best choice),
0=NO 1=YES

M6. **In the last 30 days**, how many days have you experienced medical problems (**do not include** problems if they were caused by alcohol or drugs, such as hangovers, vomiting, lack of sleep, etc.).

M7. In the last 30 days, based on the following scale, how troubled have you been by these medical problems? (Circle one of the following five choices).

0=NOT AT ALL 1=SLIGHTLY 2=MODERATELY 4=CONSIDERABLY 5=EXTREMELY

M8. How important is it to you *now* to get treated for these medical problems?

0=NOT AT ALL 1=SLIGHTLY 2=MODERATELY 4=CONSIDERABLY 5=EXTREMELY

E1. What level of education have you completed? _____

e.g. ninth grade=9, high school graduate or GED=12, two years of college=14,
four years of college=16, two years of graduate school=18, etc.

E2. How many *months* of training, technical or vocational education have you completed?

E3. Do you have a profession, skill or trade? 0=NO 1=YES _____
(please specify)

E4. Do you have a valid driver's license? 0=NO 1=YES

E5. If you *do* have a valid driver's license, do you have an automobile or car available for you to use?

0=NO 1=YES

E8. Does someone contribute to your support in any way? 0=NO 1=YES

E9. Answer this **only** if the answer to the above question (E8) was YES:

Does the support that someone else contributes make up most of (the majority of) your support? 0=NO 1=YES

E11: In the last 30 days, how many days were you paid for working (include working "off the books")?

How much money (dollars) did you receive from the following sources in the last 30 days?

E12. Employment (total "take-home" pay): _____

E13. Unemployment compensation: _____

E14. DPA, public assistance or "welfare": _____

E15. Pension, disability or social security benefits: _____

E16. "Significant other," family and/or friends: _____

E17. Illegal or unlawful source(s): _____

E18. How many people depend on you for *most of* their food, shelter, etc? _____

E19. In the last 30 days, how many days have you experienced employment problems? _____

E20. In the last 30 days, how troubled or bothered have you been by these employment problems?

0=NOT AT ALL 1=SLIGHTLY 2=MODERATELY 4=CONSIDERABLY 5=EXTREMELY

E21. How important is it to you *now* to get counseling for these employment problems?

0=NOT AT ALL 1=SLIGHTLY 2=MODERATELY 4=CONSIDERABLY 5=EXTREMELY

ND1. Write the approximate dates of abuse next to all of the drugs you have used/abused.

examples: '91 -94, '96 -now Marijuana , 9/95 -4/98, 5/99 -now Heroin

| | | | | | |
|-------|------------------|-------|------------------|-------|----------------|
| _____ | Heroin/Morphine | _____ | Amphetamine | _____ | Marijuana |
| _____ | Methadone | _____ | Cocaine/Crack | _____ | LSD |
| _____ | Other Opiates | _____ | Crack | _____ | PCP |
| _____ | Sedatives/benzos | _____ | Tobacco | _____ | Alcohol |
| _____ | Barbiturates | _____ | Other Stimulants | _____ | Inhalants/Glue |

Please fill in the appropriate space below to describe the amount of time you have used the various drugs listed during the lengths of time indicated:

| | Amount of days in the last 30 days | Amount of <i>years</i> During your lifetime | Route of Administration: 1=oral 2=nasal 3=smoking 4=sub-Q or "skin popping" 5=intravenous ("I.V.") |
|---|---|--|---|
| D1. Any alcohol use at all | | | |
| D2. Alcohol until drunk | | | |
| D3. Heroin, p-dope | | | |
| D4. Methadone/LAAM | | | |
| D5. Other opiates | | | |
| D6. Barbiturates | | | |
| D7. Other sedatives/benzos | | | |
| D8. Cocaine | | | |
| D9. Amphetamines | | | |
| D10. Cannabis, THC, pot | | | |
| D11. Hallucinogens/LSD/PCP | | | |
| D12. Inhalants, glue, etc. | | | |
| D13. Two or more substances used per day | | | |

D14. Which of the above substance(s) is the biggest (major) problem? _____

D17. How many times have you: Had "D.T's" from alcohol? _____
Overdosed on drugs? _____

D18. How many times in your life have you been treated for:
Alcohol Abuse? _____
Drug Abuse? _____

D19. How many of these times treated were for detox only?
Alcohol? _____
Drug(s) _____

D20. In the last 30 days, how much money (dollars) did you spend on:
Alcohol? _____
Drug(s) _____

D21. **In the last 30 days**, how many days have you been treated in an outpatient setting for alcohol or drug abuse (include professional counseling sessions and all self-help groups like AA, NA, SMART Recovery, etc.)?

D22. **In the last 30 days**, how many days have you experienced problems with:
Alcohol? _____
Drug(s)? _____

D23. **In the last 30 days**, how troubled or bothered have you been by these problems?

Alcohol: 0=NOT AT ALL 1=SLIGHTLY 2=MODERATELY 4=CONSIDERABLY 5=EXTREMELY

Drug(s): 0=NOT AT ALL 1=SLIGHTLY 2=MODERATELY 4=CONSIDERABLY 5=EXTREMELY

D24. How important to you **now** is treatment for these:

Alcohol: 0=NOT AT ALL 1=SLIGHTLY 2=MODERATELY 4=CONSIDERABLY 5=EXTREMELY

Drug(s): 0=NOT AT ALL 1=SLIGHTLY 2=MODERATELY 4=CONSIDERABLY 5=EXTREMELY

ND2. Do you drink caffeinated beverages? : no ___ yes ___ # _____ per day

ND7. In Patient Hospitalization(s) for drug abuse or mental health problems, if any:

| | <i>Date</i> | <i>Name of hospital, State</i> | <i>Reason</i> | <i>Did you complete?</i> |
|------|-------------|--------------------------------|---------------|--------------------------|
| i. | _____ | _____ | _____ | _____ |
| ii. | _____ | _____ | _____ | _____ |
| iii. | _____ | _____ | _____ | _____ |
| iv. | _____ | _____ | _____ | _____ |
| v. | _____ | _____ | _____ | _____ |

ND8. Were you ever enrolled in a medically supervised program using any of the following medications:

- buprenorphine
- methadone
- other (please specify) _____

ND9. Live-in Community Program(s):

| | <i>Date</i> | <i>Name of Agency</i> | <i>Agency Location</i> | <i>Successful?</i> |
|------|-------------|-----------------------|------------------------|--------------------|
| i. | _____ | _____ | _____ | _____ |
| ii. | _____ | _____ | _____ | _____ |
| iii. | _____ | _____ | _____ | _____ |

ND10. Prison Program(s):

| | <i>Date</i> | <i>Prison</i> | <i>Location</i> | <i>Successful?</i> |
|-----|-------------|---------------|-----------------|--------------------|
| i. | _____ | _____ | _____ | _____ |
| ii. | _____ | _____ | _____ | _____ |

ND12. Have you ever attended any *self help groups*? no yes If yes, list:

| <i>Name of self help group</i> | <i># of meetings attended</i> | <i>approx. dates of attendance</i> |
|--------------------------------|-------------------------------|------------------------------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

ND3. Below, describe your typical pattern of drug/alcohol use **over the last 6 months**:

example:

| | Substance Abuse | Drug | How Much | How Often | How Used |
|---|----------------------|----------------|-----------------|------------------|-----------------------|
| 1 | Worst problem | <i>Whiskey</i> | <i>1 pint</i> | <i>per day</i> | <i>drank straight</i> |
| 2 | Second worst problem | <i>Cocaine</i> | <i>1 line</i> | <i>2X / day</i> | <i>snorted</i> |
| 3 | Third worst problem | <i>Pot</i> | <i>2 joints</i> | <i>3x / week</i> | <i>smoked</i> |
| 4 | Fourth worst problem | <i>none</i> | | | |

| | Substance Abuse | DRUG | How Much | How Often | How Used |
|----------|----------------------|-------------|----------|-----------|----------|
| 1 | Worst problem | | | | |
| 2 | Second worst problem | | | | |
| 3 | Third worst problem | | | | |
| 4 | Fourth worst problem | | | | |
| 5 | Fifth worst problem | | | | |

The following table below relates to the three **DRUGS** listed on the previous page as worst, second worst, and third worst problems (if any other besides opioids):

| Signs & Symptoms | DRUG 1 | | DRUG 2 | | DRUG 3 | |
|---|--------|----|--------|----|--------|----|
| | Yes | No | Yes | No | Yes | No |
| 1. Taking drugs in larger amounts or for longer than intended | | | | | | |
| 2. Wanting to cut down or stop using the drug but not able to | | | | | | |
| 3. Spending a lot of time getting, using, or recovering from the use of the drug's effects | | | | | | |
| 4. Craving, strong desire, or urges to use the drug | | | | | | |
| 5. Not managing to do what you should do at work, home or school, because of drug use. | | | | | | |
| 6. Continuing to use the drug, even when it causes problems in social or personal relationships | | | | | | |
| 7. Giving up important social, occupational or recreational activities because of drug use | | | | | | |
| 8. Using drugs again and again, even when it puts you in danger | | | | | | |
| 9. Continuing to use, even when you know you have a physical or psychological problem that could have been caused or made worse by the drug | | | | | | |
| 10. Needing more of the drug to get the same effect, or getting less of an effect over time with the same amount of drug (tolerance) | | | | | | |
| 11. Development of withdrawal symptoms, which can be relieved by taking more of the drug | | | | | | |

ND5. Which, if any, of the following factors have contributed to your substance use? Check the item if it is relevant to **when you first started using**. Also, check the item accordingly if it is relevant to your most **recent use**. In the third column, list the related drug.

| Drug Use Factor | Early Use | Recent Use | Involved Substance <i>(examples)</i> |
|--------------------------------|---------------|---------------|---|
| To counter act anxiety | _____ | ✓ _____ | _____ <i>Klonopin</i> _____ |
| To lure others into sex | _____ ✓ _____ | _____ ✓ _____ | _____ <i>Cocaine</i> _____ |
| To try something new | _____ | _____ | _____ |
| To relieve boredom | _____ | _____ | _____ |
| To have an euphoric effect | _____ | _____ | _____ |
| To overcome shyness | _____ | _____ | _____ |
| To fit in with friends | _____ | _____ | _____ |
| To escape from work pressure | _____ | _____ | _____ |
| To escape from family pressure | _____ | _____ | _____ |
| To escape from physical pain | _____ | _____ | _____ |
| To counter act depression | _____ | _____ | _____ |
| To counter act anxiety | _____ | _____ | _____ |
| To help with sleep | _____ | _____ | _____ |
| To help wake up, get going | _____ | _____ | _____ |
| To improve performance in | _____ | _____ | _____ |
| To feel powerful and strong | _____ | _____ | _____ |
| To enhance sexuality | _____ | _____ | _____ |
| To lure others into sex | _____ | _____ | _____ |
| To boost courage | _____ | _____ | _____ |
| To help relax | _____ | _____ | _____ |
| To try something new | _____ | _____ | _____ |
| To avoid withdrawal | _____ | _____ | _____ |

ND11. Check the types of **outpatient** treatment in which you were involved:

| Type of Treatment | How Long | Completion? |
|---|----------|-------------|
| <input type="checkbox"/> a. Individual outpatient counseling or therapy | _____ | _____ |
| <input type="checkbox"/> b. Group outpatient counseling or therapy | _____ | _____ |
| <input type="checkbox"/> c. Outpatient methadone detox | _____ | _____ |
| <input type="checkbox"/> d. Outpatient methadone maintenance | _____ | _____ |
| <input type="checkbox"/> e. Drug problem intervention | _____ | _____ |
| <input type="checkbox"/> f. Marriage counseling or therapy | _____ | _____ |
| <input type="checkbox"/> g. Family counseling or therapy | _____ | _____ |
| <input type="checkbox"/> h. Counseling or therapy | _____ | _____ |

ND13. Check the items below that best describe over what you relapsed in the past:

- Money pressures piled up.
- Family pressures: spouse parent in-law child secondary relative
- Work pressures got to me.
- I can't read and that finally got to me.
- I have really low self-esteem and just didn't care for a while.
- I became lonely and depressed.
- Friends pressured me into it.
- A relative pushed it on me.
- I relapsed just after a crisis _____
- I became physically ill _____
- I became mentally ill _____
- I went back to the old hangouts _____
- I needed a pick-me-up.
- I came upon some old stash.
- Somebody close to me uses and after a while I caved in.
- I was pressured to get into dealing for some decent income.
- My boy/girlfriend pressured me into it.
- I stopped attending my support group.
- I needed relief from pain or physical distress: headaches ___ back pain ___ injury ___
Other, explain: _____
- I became disillusioned with the straight life.
- I had a physical craving out of the blue.
- Boredom got the better of me.
- My relapse was the culmination of a lot of things that slowly got out of control.
- Other: _____

ND14. The **three biggest** potential relapse triggers are:

- a. _____
- b. _____
- c. _____

ND15. Write out three really **good reasons for staying clean** and sober.

- a. _____
- b. _____
- c. _____

ND16. What motivates you to seek treatment now?

L2. Are you on probation or parole? 0=NO 1=YES

Please fill in the appropriate space below to describe how many times you have been **arrested and charged** with the following crimes listed, during the lengths of time indicated:

| | Number of times <i>before adulthood</i> | Number of times in <i>your entire lifetime</i> |
|--|--|---|
| L3. Shoplifting/vandalism | | |
| L4. Parole/probation violations | | |
| L5. Drug-related charges | | |
| L6. Forgery | | |
| L7. Weapons offense | | |
| L8. Burglary, larceny, breaking & entering | | |
| L9. Robbery | | |
| L10. Assault | | |
| L11. Arson | | |
| L12. Rape | | |
| L13. Homicide, manslaughter | | |
| L14. Prostitution | | |
| L15. Contempt of court | | |
| L16. Other crime | | |

L17. How many of the above-listed charges resulted in **convictions**? _____

Please fill in the appropriate space below to describe how many times you have been **arrested and charged** with the following crimes listed, during the lengths of time indicated:

| | Number of times <i>before adulthood</i> | Number of times in <i>your entire lifetime</i> |
|---|--|---|
| L18. Disorderly conduct, vagrancy, public intoxication or lewdness | | |
| L19. Driving while intoxicated ("DWI, DUI") | | |
| L20. Major driving violations (reckless driving, speeding, driving without a license, etc.) | | |

L21. How many **months** were you incarcerated (in jail or detention center) in your lifetime?

L23. From the list of items in questions L3-L16 and L18-L20 what was it that you were **incarcerated** for?
example: L6 (forgery), L19 (DWI/DUI)

L24. Are you presently awaiting charges, trial or sentence? 0=NO 1=YES

L25. From the list of items in questions L3-L16 and L18-L20, what is it that you are awaiting charges for?
example: L4 (parole violation) _____

L26. **In the last 30 days**, how many days were you detained or incarcerated? _____

L27. **In the last 30 days**, how many hays have you engaged in illegal activities for profit?

L28. How serious do you feel your present legal problems are?

0=NOT AT ALL 1=SLIGHTLY 2=MODERATELY 4=CONSIDERABLY 5=EXTREMELY

L29. How important to you **now** is it to get counseling or referral for these legal problems?

0=NOT AT ALL 1=SLIGHTLY 2=MODERATELY 4=CONSIDERABLY 5=EXTREMELY

L30. In the last 30 days, how much money (dollars) did you receive from illegal sources?

\$ _____

FH. Place a check mark for any of your relatives that ever had what you would call a significant drinking, drug use or psychological problem:

| | | | |
|--------------------|----------------------------------|-------------------------------|--------------------------------|
| Mother | <input type="checkbox"/> Alcohol | <input type="checkbox"/> Drug | <input type="checkbox"/> Psych |
| Father | <input type="checkbox"/> Alcohol | <input type="checkbox"/> Drug | <input type="checkbox"/> Psych |
| Brother # 1 | <input type="checkbox"/> Alcohol | <input type="checkbox"/> Drug | <input type="checkbox"/> Psych |
| Brother # 2 | <input type="checkbox"/> Alcohol | <input type="checkbox"/> Drug | <input type="checkbox"/> Psych |
| Sister # 1 | <input type="checkbox"/> Alcohol | <input type="checkbox"/> Drug | <input type="checkbox"/> Psych |
| Sister # 2 | <input type="checkbox"/> Alcohol | <input type="checkbox"/> Drug | <input type="checkbox"/> Psych |

Mother's Side:

Father's Side:

| | | | | | | |
|--------------------|----------------------------------|-------------------------------|--------------------------------|----------------------------------|-------------------------------|--------------------------------|
| Grandmother | <input type="checkbox"/> Alcohol | <input type="checkbox"/> Drug | <input type="checkbox"/> Psych | <input type="checkbox"/> Alcohol | <input type="checkbox"/> Drug | <input type="checkbox"/> Psych |
| Grandfather | <input type="checkbox"/> Alcohol | <input type="checkbox"/> Drug | <input type="checkbox"/> Psych | <input type="checkbox"/> Alcohol | <input type="checkbox"/> Drug | <input type="checkbox"/> Psych |
| Aunt | <input type="checkbox"/> Alcohol | <input type="checkbox"/> Drug | <input type="checkbox"/> Psych | <input type="checkbox"/> Alcohol | <input type="checkbox"/> Drug | <input type="checkbox"/> Psych |
| Uncle | <input type="checkbox"/> Alcohol | <input type="checkbox"/> Drug | <input type="checkbox"/> Psych | <input type="checkbox"/> Alcohol | <input type="checkbox"/> Drug | <input type="checkbox"/> Psych |

F9a-18. Have you had significant periods in which you have experienced serious problems getting along with:

| | <u>Last 30 Days</u> | <u>In Your Lifetime</u> |
|--|---------------------|-------------------------|
| Mother | No=0 Yes=1 | No=0 Yes=1 |
| Father | No=0 Yes=1 | No=0 Yes=1 |
| Brothers/Sisters | No=0 Yes=1 | No=0 Yes=1 |
| Sexual partner/Spouse | No=0 Yes=1 | No=0 Yes=1 |
| Children | No=0 Yes=1 | No=0 Yes=1 |
| Other Significant Family, Specify _____ | No=0 Yes=1 | No=0 Yes=1 |
| Close friends | No=0 Yes=1 | No=0 Yes=1 |
| Neighbors | No=0 Yes=1 | No=0 Yes=1 |
| Co-Workers | No=0 Yes=1 | No=0 Yes=1 |

F19. In the last 30 days, how many days have you had serious conflicts:

With your family _____

With other people (not family) _____

F20. In the last 30 days, how troubled or bothered have you been by *family* problems?

0=NOT AT ALL 1=SLIGHTLY 2=MODERATELY 4=CONSIDERABLY 5=EXTREMELY

F22. How important is it to you *now* to receive counseling or treatment for these *family problems*?

0=NOT AT ALL 1=SLIGHTLY 2=MODERATELY 4=CONSIDERABLY 5=EXTREMELY

NF1. Do you have children? no ___ yes ___ If yes, please fill in the following:

| Name | Age | Child's home | Custody or special concerns |
|-------|-----|--------------|-----------------------------|
| _____ | | | |
| _____ | | | |
| _____ | | | |

NF2. Would you say you have had close, long lasting, personal relationships with any of the following people in your life? (circle best answer):

| | | | | |
|-------------------|-----|----|-----------|----------------|
| Mother | YES | NO | UNCERTAIN | DID NOT KNOW |
| Father | YES | NO | UNCERTAIN | DID NOT KNOW |
| Brothers/Sisters | YES | NO | UNCERTAIN | NO SUCH PERSON |
| Significant Other | YES | NO | UNCERTAIN | NO SUCH PERSON |
| Children | YES | NO | UNCERTAIN | NO SUCH PERSON |
| Friends | YES | NO | UNCERTAIN | NO SUCH PERSON |

P2. Do you receive a pension for a psychiatric disability? yes no

- NP1 a. Have you ever seriously considered suicide? yes no
 NP1 b. Have you ever attempted suicide? yes no
 NP1 c. Have you been seriously considering suicide this week? yes no

NP1 d. If you answered “yes” to questions NP1 a, b or c, please explain when and why:

P3-10. Have you had a significant period (that was *not* a direct result of drug/alcohol use), in which you have (Circle either “No=0” or “Yes=1”)

| | <u>Past 30 Days</u> | | <u>In Your Adult Life</u> | | <u>During Childhood</u> | |
|--|---------------------|-------|---------------------------|-------|-------------------------|-------|
| Experienced serious depression | No=0 | Yes=1 | No=0 | Yes=1 | No=0 | Yes=1 |
| Experienced serious anxiety or tension | No=0 | Yes=1 | No=0 | Yes=1 | No=0 | Yes=1 |
| Experienced hallucinations | No=0 | Yes=1 | No=0 | Yes=1 | No=0 | Yes=1 |
| Experienced trouble understanding, concentrating or remembering | No=0 | Yes=1 | No=0 | Yes=1 | No=0 | Yes=1 |
| Experienced trouble controlling violent behavior | No=0 | Yes=1 | No=0 | Yes=1 | No=0 | Yes=1 |
| Experienced serious thoughts of suicide | No=0 | Yes=1 | No=0 | Yes=1 | No=0 | Yes=1 |
| Attempted suicide | No=0 | Yes=1 | No=0 | Yes=1 | No=0 | Yes=1 |
| Been prescribed medication for any psychological/emotional problem | No=0 | Yes=1 | No=0 | Yes=1 | No=0 | Yes=1 |

P11. In the last 30 days, how many days have you experienced these psychological/emotional problems (listed above)? no yes: _____

P12. In the last 30 days, how much have you been troubled or bothered by these psychological or emotional problems?

0=NOT AT ALL 1=SLIGHTLY 2=MODERATELY 4=CONSIDERABLY 5=EXTREMELY

P13. How important to you *now* is treatment for these psychological problems?

0=NOT AT ALL 1=SLIGHTLY 2=MODERATELY 4=CONSIDERABLY 5=EXTREMELY

NP2. Have you had a significant period (that was *not* a direct result of drug/alcohol use), in which you have experienced. . . . (Circle either “No” or “Yes”). [Continued on next page]

| | <u>Past 30 Days</u> | | <u>In Your Adult Life</u> | | <u>During Childhood</u> | |
|-----------------------------|---------------------|-----|---------------------------|-----|-------------------------|-----|
| Confusion | No | Yes | No | Yes | No | Yes |
| Eating Problems | No | Yes | No | Yes | No | Yes |
| Anorexia nervosa or bulimia | No | Yes | No | Yes | No | Yes |

Patient’s LAST NAME:

| | <u>Past 30 Days</u> | | <u>In Your Adult Life</u> | | <u>During Childhood</u> | |
|----------------------------------|---------------------|-----|---------------------------|-----|-------------------------|-----|
| Hearing voices that aren't there | No | Yes | No | Yes | No | Yes |
| Seeing things that aren't there | No | Yes | No | Yes | No | Yes |
| Racing thoughts | No | Yes | No | Yes | No | Yes |
| Sleep problems | No | Yes | No | Yes | No | Yes |
| Wide mood swings | No | Yes | No | Yes | No | Yes |

NP3. Please use this space to explain any major problems you have now or have had in the past that you think is important, and which is not explained elsewhere in this form:

NR1. Is it your belief that withdrawal symptoms contribute to what makes you continue to use drugs?
 yes no

NR3. Were you ever drug-free for a period of time since being addicted? yes no

NR4. What was the longest period of time totally opioid-free (including methadone) since being addicted?

NR5. Do you think *cravings* were a major factor in your relapse? yes no

NR6. Please describe your current living arrangements: _____

NR6a. Are these living arrangements good for you? Please explain: _____

MEDICAL QUESTIONNAIRE

| | Unsure | NO | YES |
|---|--------|----|-----|
| 1. Do you have any brain or neurological problems? | | | |
| 2. Have you lost consciousness or blacked out in the last 6 months? | | | |
| 3. Do you have epilepsy or a history of seizures? | | | |
| 4. Have you experienced major head trauma or had a seizure in the last 6 month? | | | |
| 5. Do you have a thyroid disorder like low or high thyroid activity | | | |
| 6. Do you have diabetes or high blood sugar? | | | |
| 7. If you have diabetes, is it difficult to keep well controlled with medications? | | | |
| 8. Do you have high blood pressure or hypertension? | | | |
| 9. If you have high blood pressure, is it difficult to keep well controlled with medication? | | | |
| 10. Have you <i>ever</i> had a myocardial infarction or heart attack? | | | |
| 11. Have you had a heart attack <i>in the last 6 months</i> ? | | | |
| 12. Do you have angina from a heart condition? | | | |
| 13. If you have angina, is it called UNSTABLE ANGINA? | | | |
| 14. Are you UNABLE to walk up two flights of stairs <i>without</i> getting short of breath, tightness your chest or chest pain? | | | |
| 15. Do you have a cardiac dysrhythmia or irregular heart beat? | | | |
| 16. Has a doctor ever told you that you have a heart murmur? | | | |
| 17. Do you have mitral valve prolapse? | | | |
| 18. Have you ever had an infection of your heart valves or “bacterial endocarditis?” | | | |
| 19. Do you have anything wrong with the valves in your heart or anything at all wrong with your heart? | | | |
| 20. Have you ever had congestive heart failure or “CHF?” | | | |
| 21. Do you have ankle swelling? | | | |
| 22. Do you smoke cigarettes? | | | |
| 23. Do you ingest drugs by smoking? | | | |
| 24. Do you have emphysema or obstructive lung disease? | | | |
| 25. Do you have asthma or wheezing of the lungs? | | | |
| 26. If you have you asthma, have you had a serious asthma attack in the last 2 weeks? | | | |
| 27. Do you now have a respiratory infection such as bronchitis, pneumonia or tuberculosis? | | | |
| 28. Have you ever had hepatitis or been infected with a hepatitis virus? | | | |
| 29. Do you currently have active hepatitis now? | | | |
| 30. Do you now have, or have you ever had cirrhosis of the liver? | | | |
| 31. Do you have reflux of stomach contents into your chest, gastroesophageal reflux disease (GERD) or hiatal hernia? | | | |
| 32. Have you ever had an eating disorder such as anorexia nervosa or bulimia? | | | |
| 33. Have you had an active ulcer of the stomach or intestine in the past month (a.k.a. gastric ulcer or duodenal ulcer) ? | | | |
| 34. Do you now have any active disease of the urinary system such as kidney stones, blood in your urine, difficulty urinating or painful urination? (do not include trouble urinating due to opiate use) | | | |
| 35. Have you ever has chemotherapy? | | | |
| 36. Do you have any infections or infectious disease now? | | | |
| 37. Do you have fibromyalgia? | | | |
| 38. Do you have now, or have you ever had Lyme Disease? | | | |

| | | | |
|---|--------|----|-----|
| | Unsure | NO | YES |
| 39. Do you suffer from any chronic pain syndrome? | | | |
| 40. Are you allergic to any medications? | | | |
| 41. FOR FEMALE PATIENTS: Are you pregnant? | | | |

If you answered “yes” to any question(s) above, please explain the details of your “yes” answer below. Example: 18 - I had bacterial endocarditis in 2007, it was successfully treated; 23 - I smoke heroin; 29 - I was diagnosed with Hepatitis C in 2008”

Please list all medications and herbal supplements you currently take, include dosages, how often you take each one, and the reason you take each one:

| Medication | Dose (strength) | How often taken | Condition treated |
|--------------------|-----------------|-------------------|-------------------|
| e.g. <i>Zoloft</i> | <i>100 mg</i> | <i>once a day</i> | <i>depression</i> |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Please **list** all **medications** and foods that **you are allergic to**, and include what happens when you take that medication or food:

Please list any other information you want to: _____

Thank you for your time and effort completing this form !