Opioid Use History

When was the first time you used an opioid (heroin or painkiller)? _____

Name of drug: _____Route: ☐ Oral (by mouth) ☐ Snorted ☐ Smoked ☐ Injected

Was this prescribed by a physician? ☐ Yes ☐ No If yes, did you use as directed? ☐ Yes ☐ No

Have you also used other types of opioid drugs? ☐ Yes ☐ No

If yes, please list them: _____

When did you when you began using an opioid every day? _____

When did you first became dependent, or get sick if you did not use regularly? _____

Have you ever injected opioids or other drugs? ☐ Yes ☐ No

Since first becoming dependent, have you had any periods when you did not misuse opioids? ☐ Yes ☐ No

If yes, approximate dates when you were opioid free:_____

What were the circumstances? ☐ On my own ☐ With outpatient treatment, therapy, or self-help groups

☐ Live-in program ☐ I was on methadone ☐ I was on buprenorphine (Suboxone)

☐ Incarcerated, on parole, probation, etc. ☐ Other: _____

Please complete this chart for all opiates you have used

Name of opioid drug	Route(s) of use (oral, snort, smoke, inject)	How much used	Dates used	Prescribed? Yes or No	Used in past 30 days? Yes or No

Opioid Dependence Treatment History

Dates	Type of treatment (methadone, buprenorphine, counseling, residential, other)	Where did you get your treatment?	Why did you leave treatment?	How long did you remain drug free after you left treatment?

Current Opioid Use

Current opioid(s) used: _____

Route of use: ☐ Oral (by mouth) ☐ Snorted ☐ Smoked ☐ Injected

How much do you use every day? _____How many times a day do you use? _____

When did you last use? Date:_____ Time: _____ Amount: _____

Are you in withdrawal now? ☐ Yes ☐ No

If yes, what withdrawal symptoms do you have right now?

( ) Generalized discomfort	( ) Diarrhea	( ) Headache
( ) Hot/cold	( ) Runny nose	( ) Weakness
( ) Sweats	( ) Watery eyes	( ) Anxiety, irritability
( ) Goosebumps	( ) Sneezing	( ) Restlessness, agitation
( ) Stomach ache	( ) Yawning	( ) Tremors, shakes
( ) Nausea	( ) Muscle aches, cramps	( ) Sleep disturbance
( ) Vomiting	( ) Bone, joint aches	( ) Craving
( )	( )	( )

If 1 means "I feel fine" and 10 means "the worst withdrawal ever," rate how you feel now on a scale of 1 – 10 (Please circle a number):

1	2	3	4	5	6	7	8	9	10
I'm fine		A little sick		Moderately sick		Very sick		Worst ever	