Appendix C: Initial Patient Assessment Form

ABOUT YOURSELF:

Please complete the following questionnaire as accurately and honestly as possible so that we can determine what kind of treatment would serve you best.

NAME _____ _____
(first) (last)
DATE _____
HEALTH CARD # _____ VERSION CODE: _____
DATE OF BIRTH _____
(year/month/day)
ADDRESS _____ APT # _____
CITY _____ POSTAL CODE _____
PHONE day ( ) _____ evening ( ) _____

CONTACT IN CASE OF EMERGENCY (state relationship)
_____

CONTACT'S PHONE ( ) _____

WHO REFERRED YOU? _____

GENDER: ❑ male ❑ female

DRUG HISTORY:

DRUG	AMOUNT USED	HOW LONG DAILY USER	ROUTE TAKEN	FIRST USED	LAST USED
Heroin					
Other Narcotics					
Cocaine					
Barbiturates (Fiorinal)					
Amphetamines					
Alcohol					
Cannabis (Pot, Hash)					
Cigarettes (packs per day)					
Benzodiazepines (Valium, Ativan)					

PRESCRIPTION MEDICATIONS:

(Any medications you regularly take or are prescribed, amount and frequency): none ❑
or, give details_____
_____
_____

Are you now or have you ever been prescribed narcotics (e.g., Tylenol #3, Percodan, Percocet, Dilaudid, Talwin, morphine) for an extended period of time (e.g., for more than four weeks?) ❑ yes ❑ no narcotic name _____

Amount prescribed _____ (per week/month) For how long?_____ (weeks/months/years)

For what reason was it prescribed?
_____
_____

If it has been discontinued, when and why? _____
_____

DRUG ALLERGIES:

none ❑ or, give details:
_____
_____

(any medications you can't take, and WHY NOT?)_____
_____

PAST MEDICAL HISTORY: (circle and give year)

Hepatitis A..... …neg/pos/never tested/don't know
Hepatitis B.....neg/pos/immune/vaccinated/carrier/never tested/don't know
Hepatitis C.....neg/pos/never tested/don't know
HIV..... ……...neg/pos (_____)/never tested/don't know
date of last test
Tuberculosis skin test..... neg/pos (_____)/never tested/don't know
date of last test
For the above questions, where was the test done, and where are the results now?
_____
_____

Year of first i.v. drug use . . (_____)/never
History of needle sharing. . yes/no
(including cotton, spoons, filters, etc.)
overdoses . . . . . yes/no
asthma . . . . . yes/no
seizures . . . . . yes/no
operations . . . . . yes/no
migraines . . . . . yes/no
back problems . . . . . .yes/no
ulcers . . . . . yes/no
heart problems . . . . . .yes/no
car accidents . . . . . yes/no
other: _____
(give year and type): _____

Name and address of your family doctor: _____

Is your doctor aware of your drug problem? ❑ yes ❑ no

WOMEN ONLY:

1. When was the first day of your last menstrual period ?_____
2. Current method of contraception ? The Pill/condoms/other:_____
3. Is there any chance you might be pregnant ? ❑ yes ❑ no

EMOTIONAL HEALTH:

Have you ever been treated by a family doctor or psychiatrist for:

anxiety? ❑ yes ❑ no

depression? ❑ yes ❑ no

Have been admitted to a psychiatric facility? ❑ yes ❑ no

Received treatment for any other emotional problems? ❑ yes ❑ no

Were you abused? (mentally, sexually or physically?) ❑ yes ❑ no

Have you ever attempted suicide? ❑ yes ❑ no

Are you currently depressed or suicidal? ❑ yes ❑ no

FAMILY HISTORY:

(Any family history of medical problems like alcohol or drug abuse, depression, heart disease etc.)

mother: _____ father:_____
(age) (age)
brothers, sisters, others _____

DRUG TREATMENT PROGRAMS:

(Including attempts at detox), program name, when, how long did you stay clean/ why failed?
1. _____
2. _____
3. _____

SOCIAL HISTORY:

Are you: married/single/separated/divorced/common-law/widowed
Children?_____ Whose custody are the children in? _____

Who lives in your household? _____

Do they abuse alcohol/drugs? ❑ yes ❑ no

Are the people close to you aware of your drug problem? ❑ yes ❑ no

Usual occupation: _____ Are you currently employed ? ❑ yes ❑ no

Last job held: _____ From when _____ to _____

Highest level of education: _____

Are you receiving: welfare/FBA/pension/UI/none/other?

Do you drive a car? ❑ yes ❑ no

LEGAL STATUS:

1. Are you currently on probation or parole? ❑ yes ❑ no
if yes, until when ? _____

2. Is treatment a condition of your probation? ❑ yes ❑ no
if yes, when ? _____

3. Do you have any Court dates pending? ❑ yes ❑ no
if yes, when ? _____

4. Do you have previous convictions? ❑ yes ❑ no
if yes, for what ?_____

5. Have you been incarcerated? ❑ yes ❑ no
if yes, for what ?_____

6. How long have you been in jail for in total? _____

7. Have you been charged with impaired driving? ❑ yes ❑ no

8. Have you been charged with a crime that included a weapon or violence? ❑ yes ❑ no

ABOUT YOUR ADDICTION:

In the last 12 months:
Do you need more and more of the drug you are using to get the same effect? ❑ yes ❑ no
Describe what symptoms you experience if you suddenly stop taking the drug:
_____
_____

Do you frequently take more drugs than you planned, or use it for longer than you planned to? ❑ yes ❑ no

Have you had many unsuccessful attempts to cut down on your drug use? ❑ yes ❑ no

Do you spend a lot of your day getting, using, and recovering from the effects of drugs? ❑ yes ❑ no

Have you given up work, social or other things you used to do because of your drug use? ❑ yes ❑ no

Do you keep taking drugs, despite the harm and problems it is causing you? ❑ yes ❑ no

Why have you come for treatment at this time? _____
_____

What type of treatment do you feel that you need?_____
_____

What are your goals for treatment? _____
_____

PHYSICAL EXAM:

Name: _____ Date of exam: _____

GENERAL _____ BP_____ /_____
HR _____ /min
PUPILS: normal/pinned/dilated FUNDI
CHEST: clear/other
CVS: murmur/other
ABDO: tender enlarged liver/spleen other
SKIN: tracks abscess tattoos piercing other
LYMPHADENOPATHY: ❑ yes ❑ no
OTHER: _____

ASSESSMENT:
Meets criteria for opioid dependence: _____
Suitable for medical detoxification:_____
Suitable for methadone: _____
Co-morbidity: _____
Psychiatric: _____
Medical: _____

Concurrent substance abuse: Benzo/Cocaine/Crack/Etoh/Barbs/Amp/THC

PLAN:
1. MEDICAL DETOX – discussed risks/ handout given/ patient declined detox
2. BLOOD WORK – including pretest counselling for HIV, Hepatitis B, C
3. METHADONE BENEFITS/DRAWBACKS – discussed
4. LETTER OF UNDERSTANDING COPY GIVEN REVIEWED SIGNED
5. UDS DRUG SCREENS FOR TOXICOLOGY
6. RELEASE OF INFORMATION SIGNED
7. REFERRED FOR SECOND ASSESSMENT (if needed)
8. RETURN FOR CPE ON: _____
9. OTHER:_____

Physician's signature: _____ Date: _____