RISE Recovery
Intake Questionnaire for
Prospective (Suboxone) Patient

Powered by ONE Health Ohio

Name: _____ Date of Birth: _____
(Please print)

Home Phone: _____ Best time to call this number: _____

OK to leave a message? ☐ Yes ☐ No Does phone require caller ID? ☐ Yes ☐ No

Cell Phone: _____ Best time to call this number: _____

OK to leave a message? ☐ Yes ☐ No Does phone require caller ID? ☐ Yes ☐ No

Please answer the following questions this will allow our staff to develop your individualized plan of treatment.

1. Why are you interested in Suboxone treatment? (Please Print)

   _____

   _____

2. What benefits do you expect from Suboxone treatment? (Please Print)

   _____

3. Are you currently being treated with Suboxone? ☐ Yes ☐ No
   a. If yes, how long have you been in Suboxone treatment: _____
   b. If yes, why are you interested in starting Suboxone treatment with ONE Health Ohio?

      _____

4. Have you been previously treated with Suboxone? ☐ Yes ☐ No

   If yes, list your present and/or past Suboxone and/or Alcohol treatment dates and locations: (Please Print)

   1. Date:_____ Location:_____ Suboxone ☐ Alcohol ☐
   2. Date:_____ Location:_____ Suboxone ☐ Alcohol ☐
   3. Date:_____ Location:_____ Suboxone ☐ Alcohol ☐
   4. Date:_____ Location:_____ Suboxone ☐ Alcohol ☐

5. Past Opiate use:
   a. Did you use Heroin? ☐ Yes ☐ No
   b. Did you use pills? ☐ Yes ☐ No
   c. Did you use IV? ☐ Yes ☐ No

6. What caused you to start on opiates originally? (Please Print)

_____

7. Are the reasons listed in #6, currently a problem? ☐ Yes ☐ No

8. Have you had infections, surgeries or hospitalizations due to your drug use? ☐ Yes ☐ No

9. If you answered #8 YES please list any surgeries or hospitalizations due to your drug use here : (Please print)

1._____ 6. _____

2. _____ 7. _____

3. _____ 8. _____

4. _____ 9. _____

5. _____ 10. _____

10. Will you have trouble stopping any other drugs? ☐ Yes ☐ No

11. Do you have Narcan at home? ☐ Yes ☐ No (You can get it from CVS)

12. Please list your past and present medical problems: (Please print)

1._____ 6. _____

2. _____ 7. _____

3. _____ 8. _____

4. _____ 9. _____

5. _____ 10. _____

13. Who will provide for your medical care during this time?

Name of Provider: _____ Office Phone: _____
(Please print)

14. Have you been tested for hepatitis C and B and HIV? ☐Yes ☐No

a. Hepatitis B: Do you know the results? ☐Yes ☐No Positive:☐ Negative:☐

b. Hepatitis C: Do you know the results? ☐Yes ☐No Positive:☐ Negative:☐

c. HIV: Do you know the results? ☐Yes ☐No Positive:☐ Negative:☐

15. Have you gotten the Hepatitis B and A shots? ☐Yes ☐No

16. Females: Are you currently using a method of birth control? ☐ Yes ☐ No

17. List your family medical history: (Please Print)

1._____ 6. _____

2. _____ 7. _____

3. _____ 8. _____

4. _____ 9. _____

5. _____ 10. _____

18. List any family psychiatric history: (Please Print)

1.Depression: ☐Yes ☐No Relationship: _____

2. Schizophrenia: ☐Yes ☐No Relationship: _____

3. Bipolar Disorder: ☐Yes ☐No Relationship: _____

4. Anxiety: ☐Yes ☐No Relationship: _____

5. Panic Attacks: ☐Yes ☐No Relationship: _____

6. Other: _____ Relationship: _____

19. List any family history of addiction or substance abuse disorders: (Please Print)

1. Addiction:☐ Substance Abuse:☐ Relationship: _____

2. Addiction:☐ Substance Abuse:☐ Relationship: _____

3. Addiction:☐ Substance Abuse:☐ Relationship: _____

4. Addiction:☐ Substance Abuse:☐ Relationship: _____

5. Addiction:☐ Substance Abuse:☐ Relationship: _____

20. Are you involved with the legal system or currently on probation ☐ Yes ☐ No

21. Do you have a place to stay and food to eat? ☐ Yes ☐ No

22. Do you have any supportive family or friends who can help you with your recovery? ☐ Yes ☐ No

23. Where you live currently, is anyone addicted to drugs or alcohol? ☐ Yes ☐ No

If yes please list: (Please Print)

1. Name _____ Relationship:_____ Substance:_____

2. Name _____ Relationship:_____ Substance:_____

3. Name _____ Relationship:_____ Substance:_____

4. Name _____ Relationship:_____ Substance:_____

24. Do you have any childhood or adult trauma (physical or emotional abuse) that contributes to your issues? ☐Yes ☐No

If yes please list below: (Please Print)

1._____ 6. _____

2. _____ 7. _____

3. _____ 8. _____

4. _____ 9. _____

5. _____ 10. _____

25. Do you currently work? ☐ Yes ☐ No

If yes, where are you employed: _____

(Please print)

26. Are you on disability? ☐ Yes ☐ No

27. Are you currently receiving treatment from a psychiatrist or counselor? ☐ Yes ☐ No

If yes please list:

Name: _____

(Please print)

Office Phone Number: _____

If no you will need a psychiatrist or counselor, we can refer you if you would like us to.

28. What are the major sources of stress in your life? (Please print)

1._____ 3. _____

2. _____ 4. _____

3. _____ 6._____

29. What are your major strengths to deal with the stress in your life? (Please print)

1._____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

30. What coping methods have you developed to deal with your triggers to relapse? (Please print)

1._____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

31. Do you have any conditions that makes it difficult for you to provide routine urine specimens? ☐ Yes ☐ No

If yes please list: (Please print)

1. Condition: _____

2. Condition: _____

The safety of your Suboxone medication or prescription will be your responsibility.

Requests for replacement Suboxone medication or prescriptions will not be honored.

I understand that by signing this form, I attest that each of the statements I have provided here are true, to best of my knowledge.

_____ _____

Signature Date of Birth

_____ _____

Printed Name Date Completed