OFFICE USE ONLY

HR ________ O2 Sat ________ BP ________

weight ________ temp ________

Patient Name ____________________ DOB ________

Date ____________________

	Not at all				Very Much
I have experienced cravings for opiates/heroin	0	1	2	3	4
I have had a good appetite	0	1	2	3	4
I have had trouble sleeping	0	1	2	3	4
I have had stomach aches/nausea	0	1	2	3	4
I have had constipation	0	1	2	3	4
I have had headaches	0	1	2	3	4
I have had trouble taking my medication	0	1	2	3	4
I have had muscle and bone discomfort	0	1	2	3	4
I have had anxiety, depression or other emotional problems	0	1	2	3	4
I have had a change in my work or living status	0	1	2	3	4
I have had a change in my stress level	0	1	2	3	4

Drugs used since last visit: (check the box if used)

- Methamphetamine ☐
- Alcohol ☐
- Heroin ☐
- Marijuana ☐
- Opioids/Pills ☐
- Other Benzos ☐

Current Medications Prescribed: ____________________

Date and time of your last Suboxone dose: ____________________