

**Buprenorphine/Naloxone Maintenance Treatment  
Intake Questionnaire for Patient Treatment-Planning Questions**

**Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

Please answer the following questions which will help us design your plan of treatment:

What is the best time of day and day of week for you for clinic visits?

\_\_\_\_\_

Are there any months of the year when you may have difficulty making it in for appointments?

\_\_\_\_\_

Is there any problem that makes it hard for you to give routine urine specimens?

\_\_\_\_\_

Do you have any disabilities that make it hard for you to read labels or count pills?

\_\_\_\_\_

What are your reasons for being interested in Buprenorphine/Naloxone treatment?

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\_\_\_\_\_

What "triggers" do you know which have put you in danger or relapse in the past or which might in the future?

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What coping methods have you developed to deal with these triggers to relapse?

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What plans do you have for the coming year?

Work? \_\_\_\_\_

Home? \_\_\_\_\_

Other? \_\_\_\_\_

What kinds of help would you like from your counselor?

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What are your strengths and skills to handle take-home Buprenorphine/Naloxone (Suboxone)?

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What worries do you have about extended take homes?

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Is anyone in your home actively addicted to drugs or alcohol?

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What are the major sources of stress in your life?

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What family or significant others will be supportive to you during your treatment?

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Would you be willing to sign a release so that the person(s) identified above can be spoken to regarding your treatment?

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What medical care will you have in the coming year?

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How will you comply with the annual physical examination and laboratory and urine testing requirements?

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Have you ever been treated for a psychiatric problem or mental illness or prescribed psychiatric medications?

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