Bradford Medical Centre
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Methadone/Suboxone Registration Form

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

Patient Last name: ..... First name: .....

Name of family doctor: .....

How did you hear from us? .....

Drug History:

Drug	Amount used	How long daily user	Route taken	First used	Last used
Heroin					
Other narcotics					
Cocaine					
Benzodiazepines (valium, Ativan)					
Barbiturates(fiorinal)					
Amphetamines					
Cannabis(pot, hash)					
Cigarettes (packs per day)					
Alcohol					

Past Medical History: (Circle/Check and given year)

- Hepatitis A: ☐neg ☐pos ☐unknown
- Hepatitis B: ☐neg ☐pos ☐immune ☐vaccinated ☐carrier ☐unknown
- Hepatitis C: ☐neg ☐pos ☐unknown
- HIV: ☐neg ☐pos (date of test.....) ☐unknown
- For the above questions, where was the test done, and where are the results now?
  ……
  ……
- History of I.V. drug use: ☐Yes ☐Never
- History of needle sharing: ☐Yes ☐Never
- History of overdose: ☐Yes ☐Never
- Car accident: ☐Yes ☐Never

Women Only:

First day of last menstrual period: .....

Current method of contraception: .....

Is there any chance that you might be pregnant?.....

Emotional health:

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

- Anxiety? ☐Yes ☐No
- Depression? ☐Yes ☐No
- Bipolar: ☐Yes ☐No
- Schizophrenia: ☐Yes ☐No
- Other psychiatry disease? ☐Yes ☐No
- Have you ever been admitted to a psychiatry facility? ☐Yes ☐No
- Were you abused? (Mentally, sexually, verbally, physically): ☐Yes ☐No
- Have you ever attempted suicide? ☐Yes ☐No
- Are you currently depressed or suicidal? ☐Yes ☐No
- Any family history of alcohol abuse, drug abuse, suicide? ☐Yes ☐No
  If yes for family history please explain:
  .....
  .....

Drug treatment program: such as methadone clinic or detox: ☐Yes ☐No

- If yes please explain: when, how long did you stay clean, why it failed?
  .....
  .....
  .....

Family history:

- Who lives in your household? ☐Yes ☐No

- Any children? ☐Yes ☐No - whose custody are the children in? .....
- Do they abuse alcohol/drugs? ☐Yes ☐No
- Are people close to you aware of your drug problem? ☐Yes ☐No
- Are they supportive for your decision to join the program? ☐Yes ☐No

Legal status:

- Are you currently on probation or parole? ☐Yes ☐No
  If yes until when? .....

- Is treatment a condition of your probation? ☐Yes ☐No
  If yes, when?.....

- Do you have any court dates pending? ☐Yes ☐No
  If yes, when?.....

- Do you have previous convictions? ☐ Yes ☐No
  If yes for what? .....

- Have you been incarcerated? ☐Yes ☐No
  If yes for what? .....

- Have you been in jail? ☐Yes ☐No
  If yes for how long in total? .....

- Have you been charged with impaired driving? ☐Yes ☐No

- Have you been charged with a crime that included a weapon or violence? ☐ Yes ☐No

About your addiction: In the last 12 month

- Do you need more and more of the drug you are using to get the same effect? ☐Yes ☐No
- What symptoms do 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 your 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

Do you drive a car? ☐Yes ☐No

Why have you come for treatment at this time?

.....

What type of treatment you feel that you need?

.....

What are your goals for treatment?

.....

I confirm that information above is accurate to the best of my knowledge.

Patient Signature: .....

Date: ……..