Top Care Health Centre
10171 Yonge Street
Richmond Hill ON, L4C 1T5
Tel: (365) 887-4499
Fax: (365) 887-4550

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: ……..