

Substance Use Questionnaire

Name: _____

Date: _____

For which substance are you seeking treatment? _____

When did you first start using this substance? _____

Have you ever tried to stop before? Yes No

If yes, what method(s) have you tried? Cold turkey Rehab Counseling
 Other NA / AA Suboxone Methadone

How much are you using now? _____

Have you ever been arrested for the following? No
 DWI Drug Related Domestic Violence

Have you ever attended: AA Past Current
NA Past Current
CA Past Current

Is there a history in your family of substance abuse? Yes No

Have you ever experienced any of the following withdrawal symptoms?

<input type="checkbox"/> Blackouts	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Seizures	<input type="checkbox"/> Body Aches
<input type="checkbox"/> Tremors	<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Sweats	<input type="checkbox"/> Nausea and Vomiting

Over time, have you had to increase the dose to maintain the same effect? Yes No

Do you feel that taking the substance has had a negative impact on your life? Yes No

Are you ready to make a change and stop taking this substance? Yes No

Are you willing to seek some form of counseling in addition to the drug therapy? Yes No

When was the last time you took any of the substance? _____

Signature: _____

Please complete the Substance use Profile on the next page

Substance Use Profile

Cigarettes: No In the past Now _____ packs per day for _____ years

Alcohol: No In the past Now _____ drinks per day / week / month
beer / wine / liquor

Cocaine No Past Now How much _____ Last used _____

Crystal Meth No Past Now How much _____ Last used _____

Heroin No Past Now How much _____ Last used _____

Inhalants No Past Now How much _____ Last used _____

LSD /
Hallucinogins No Past Now How much _____ Last used _____

Marijuana No Past Now How much _____ Last used _____

Methadone No Past Now How much _____ Last used _____

Pain Killers No Past Now How much _____ Last used _____

PCP No Past Now How much _____ Last used _____

Stimulants /
Amphetamines No Past Now How much _____ Last used _____

Sleeping Pills No Past Now How much _____ Last used _____

Ecstasy No Past Now How much _____ Last used _____

Other No Past Now How much _____ Last used _____

Please provide any additional information you feel would be helpful for the Doctor to know

Name: _____

John M. Willis, DO, MMM, FACOI
2800 E. Broad Street
Suite 512
Mansfield, TX 76063
Ph. (817) 473-6867
Fax (817) 453-0954

TELEPHONE APPOINTMENT REMINDER CONSENT

I _____ give John M. Willis, DO
Patient Name (Print)

and members of his/her staff working at the location indicated above my permission to call me prior to an appointment to remind me of the appointment date and time.

I would prefer to be called at (check all that apply):

- Home _____
 Work _____
 Cell _____

Yes, this office may leave (check all that apply):

- Voice mail at my Home Voice mail at my Work Voice mail on my Cell
 Messages with people at my Home Messages with people at my Work

I understand that I may withdraw this consent at any time, either verbally or in writing except to the extent that action has been taken on reliance on it. This consent will last while I am being treated for opioid dependence by the physician specified above unless I withdraw my consent during treatment. This consent will expire 365 days after I complete my treatment, unless the physician specified above is otherwise notified by me.

Patient Signature

Date

Parent/Guardian Signature

Parent/Guardian Name (Print)

Date

Witness Signature

Witness Name (Print)

Date

John M. Willis, DO, MMM, FACOI

2800 E. Broad Street

Suite 512

Mansfield, TX 76063

Ph. (817) 473-6867

Fax (817) 453-0954

CONSENT TO RELEASE/RECEIVE CONFIDENTIAL INFORMATION

_____ authorize **John M. Willis, DO** _____ at the above address to:

Receive my medical history information from the following physicians:

Receive my treatment records from the following therapist

Release my treatment information/records to the following healthcare professional

Release my treatment information to the health insurance company listed below for billing purposes

This information is for the following purposes (any other use is prohibited): _____

I understand that I may withdraw this consent at any time, either verbally or in writing except to the extent that action has been taken in reliance on it. This consent will last while I am being treated for opioid dependence by the physician specified above unless I withdraw my consent during treatment. This consent will expire 365 days after I complete my treatment, unless the physician specified above is otherwise notified by me.

I understand that the records to be released may contain information pertaining to psychiatric treatment and/or treatment for alcohol and/or drug dependence. These records may also contain confidential information about communicable diseases including HIV (AIDS) or related illness. I understand that these records are protected by the Code of Federal Regulations Title 42 Part 2 (42 CFR Part 2) which prohibits the recipient of these records from making any further disclosures to third parties without the express written consent of the patient.

I acknowledge that I have been notified of my rights pertaining to the confidentiality of my treatment information/records under 42 CFR Part 2, and I further acknowledge that I understand those rights.

Patient Signature

Date

Parent/Guardian Signature

Parent/Guardian Name (Print)

Date

Witness Signature

Witness Name (Print)

Date

Confidentiality of Alcohol and Drug Dependence Patient Records

The confidentiality of alcohol and drug dependence patient records maintained by this practice/program is protected by federal law and regulations. Generally, the practice/program may not say to a person outside the practice/program that a patient attends the practice/program, or disclose any information identifying a patient as being alcohol or drug dependent unless:

1. The patient consents in writing;
2. The disclosure is allowed by a court order, or
3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or practice/program evaluation.

Violation of the federal law and regulations by a practice/program is a crime. Suspected violations may be reported to appropriate authorities in accordance with federal regulations.

Federal law and regulations do not protect any information about a crime committed by a patient either at the practice/program or against any person who works for the practice/program or about any threat to commit such a crime.

Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under state law to appropriate state or local authorities.

John M. Willis, DO, MMM, FACOI
2800 E. Broad Street
Suite 512
Mansfield, TX 76063
Ph. (817) 473-6867
Fax (817) 453-0954

PATIENT TREATMENT CONTRACT

Patient Name _____ Date _____

As a participant in buprenorphine treatment for opioid misuse and dependence, I freely and voluntarily agree to accept this treatment contract as follows:

1. I agree to keep and be on time to all my scheduled appointments.
2. I agree to adhere to the payment policy outlined by this office.
3. I agree to conduct myself in a courteous manner in the doctor's office.
4. I agree not to sell, share, or give any of my medication to another person. I understand that such mishandling of my medication is a serious violation of this agreement and would result in my treatment being terminated without any recourse for appeal.
5. I agree not to deal, steal, or conduct any illegal or disruptive activities in the doctor's office.
6. I understand that if dealing or stealing or if any illegal or disruptive activities are observed or suspected by employees of the pharmacy where my buprenorphine is filled, that the behavior will be reported to my doctor's office and could result in my treatment being terminated without any recourse for appeal.
7. I agree that my medication/prescription can only be given to me at my regular office visits. A missed visit may result in my not being able to get my medication/prescription until the next scheduled visit. Prescriptions will not be refilled after hours or on the weekends.
8. I agree that the medication I receive is my responsibility and I agree to keep it in a safe, secure place. I agree that lost medication will not be replaced regardless of why it was lost.
9. I agree not to obtain medications from any doctors, pharmacies, or other sources without telling my treating physician.
10. I have been informed that buprenorphine, as found in Suboxone, is a narcotic analgesic, and thus it can produce a 'high'; I know that taking Suboxone regularly can lead to physical dependence and addiction, and that if I were to abruptly stop taking Suboxone after a period of regular use, I could experience symptoms of opiate withdrawal. I also understand that combining Suboxone with benzodiazepine medications (including but not limited to Valium, Klonopin, Ativan, Xanax, Librium, Serax) has been associated with severe adverse events and even death. I also understand that I should not drink alcohol with Suboxone since it could possibly interact with Suboxone to produce medical adverse events such as reduced breathing or impaired thinking. I agree not to use benzodiazepine medications or to drink alcohol while taking Suboxone.
11. I agree to take my medication as my doctor has instructed and not to alter the way I take my medication without first consulting my doctor.

- 12. I understand that medication alone is not sufficient treatment for my condition, and I agree to participate in counseling as discussed and agreed upon with my doctor and specified in my treatment plan.**
13. I am not pregnant, and will not attempt to become pregnant. If a female, I will not have unprotected sex while I am taking Suboxone, because of the unknown safety of buprenorphine during pregnancy. I will tell my doctor if I become pregnant so that other treatment options can be discussed with me.
14. I agree that I will be open and honest with my physician and counselors and inform staff about cravings, potential for relapse to the extent that I am aware of such, and specifically about any relapse which has occurred --before a drug test result shows it.
15. I agree to provide random urine samples and have my doctor test my blood alcohol level.
16. I understand that violations of the above may be grounds for termination of treatment.

Date _____

Patient Signature