Opioid Treatment
Periodic/Quarterly Assessment

►**1. Date Collected:**

►**ESM Client ID:**

Provider ID:

All Questions marked with a ► must be completed ***Boxes marked with ✶ = Refer to key at end of form***

First Name: **Middle Initial:** **Last Name:** **Suffix:**

► **2. Is your current medication-assisted treatment for withdrawal management or maintenance?** ☐ Maintenance ☐ Withdraw Management

► **3. Current Employment status:** ☐Work full time ☐Unemployed, seeking work ☐Unable to work ☐Work part time ☐Unemployed, not seeking work ☐Other

► **4. Are you currently pregnant?** ☐ Yes ☐ No

► **5. Number of arrests in the past 3 months** *(0-93):* ☐

► **6. During the past 3 months, have there been services you think you have needed but have not been provided to you by the program or by a referral from the program?***

1☐None 2☐ A Few 3☐Some 4☐A Lot

► **7. During the past 3 months, do you feel you have been treated fairly by the program staff?**

1☐Not at all 2☐Sometimes 3☐Most of the Time 4☐Always

► **8. Frequency of drug use in the past 3 months** *(enter one code for a –f)*

Frequency of Last Use Codes: ***1*** *= No use* ***2*** *= Less than once per month* ***3*** *= 1-3 times per month* ***4*** *= 1-2 times per week* ***5*** *= 3-6 times per week* ***6*** *= Daily*

a. Cocaine or crack ☐ **c. Other narcotics or opiates** ☐ **e. Alcohol** ☐

b. Heroin ☐ **d. Marijuana** ☐ **f. Injected drug use** ☐

► **9. In general, how would you describe your current health?**

1☐Excellent 2☐Very Good 3☐Good 4☐Fair 5☐Poor

► **10. During the past 3 months, how much difficulty did you have doing your daily activities, both inside and outside the home, due to physical or emotional problems?**

1☐None 2☐A little bit 3☐Some 4☐Quite a bit 5☐Unable to do daily activities

► **11. During the past 3 months, how many nights were you hospitalized for physical problems?** *(0 -92):* ☐

► **12. How many overdoses have you had in the past three months?** *(0-99)* ☐

► **13. During the past 3 months, how many nights were you in a detox facility?** *(0 -92):* ☐

► **14. During the past 3 months, how many visits to an emergency room and/or urgent care facility did you make?** *(0 -100):* ☐

► **15. During the past 3 months, how much were you distressed (bothered) by:**

	1-- Not at all	2 -- A little/slightly	3 -- Moderately	4 -- A lot/extremely
a. Nervousness or shakiness inside?				
b. Suddenly being scared for no reason?				
c. Feeling fearful?				
d. Spells of terror or panic?				
e. Feeling that something bad is going to happen?				

16. In the past 3 months, how much were you distressed (bothered) by:

	1 -- Not at all	2 -- A little/slightly	3 -- Moderately	4 --A lot/extremely
a. Blaming yourself for things?				
b. Feeling blue?				
c. Worrying too much about things?				
d. Feeling no interest in things?				
e. Feeling hopeless about the future?				
f. Feeling worthless?				
g. Feeling guilty for things that may not be your fault?				

17. In the past 3 months, did you think about suicide? 1☐Yes 2☐No

18. In the past 3 months, did you attempt suicide? 1☐Yes 2☐No

19. In the past 3 months, how supportive would you say the people closest to you are of your seeking substance abuse treatment at this time?

1☐Not supportive or opposed 2☐Not very supportive 3☐Somewhat supportive 4☐Very supportive

20. In the past 3 months, would you say that none of the people, a few of the people, or most of the people you are close to are currently abusing drugs? 1☐None 2☐One or a few3 ☐Most

RECORD DATA

21. Does client have a current prescription opiate(s)? 1☐Yes 2☐No

22. Does the client have a current prescription for Benzodiazepine(s)? 1☐Yes 2☐No

23. Urinalysis Results Received Over the Past 3 Months. EXCLUDE the client's initial urine screen

Drug	# of Urine Screens for Drug	# of Testing Positive for Drug
Cocaine		
Opiates		
Methadone		
Benzodiazepines		
Other Drugs		

24. Which medication-assisted treatment is the client currently receiving? ☐Methadone ☐Buprenorphine ☐Naltrexone ☐Other

23a If Other, specify _____

If client is currently using Naltrexone or Other , skip Q24 and 24a. go to Q25

25. Has the client received a dose in the past 2 weeks? ☐Yes ☐No

24a. What was the client's last dose? (mg):

26. In what phase of treatment was the client?

☐Active treatment ☐Stabilization treatment ☐Medically supervised withdrawal ☐Medical maintenance