The Commonwealth of Massachusetts
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Department of Public Health
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Pharmacy Substance Use Disorder (PSUD) Program

PSUD PARTICIPANT SELF-REPORT

Name:_____ Date:_____
(please print)

Date Entered PSUD:_____

INSTRUCTIONS: The purpose of this self-report is to provide you with a way to give PSUD a sense of where you're at with your recovery process and highlight any changes in your life. It also gives you an opportunity to identify areas where you might need additional assistance or support from PSUD.

Are there any changes in your address/contact information? ☐ No ☐ Yes; see below.

change from:	change to:

How many AA/NA meetings are you attending per week? _____

Who is your sponsor? (first name & last initial) _____

What's your home group? (name & location) _____

What professional support group are you attending? _____

Any recent medical/surgical/psychiatric problems? _____

Have you been prescribed any new medications? ☐ No ☐ Yes (if yes, please attached updated medication report)

Are there any changes with your PCP or psychiatrist? ☐ No ☐ Yes; see below.

change from:	change to:

Are there any changes with your individual or group therapist? ☐ No ☐ Yes; see below.

change from:	change to:

Are there any changes in your employment? ☐ No ☐ Yes; see below.

change from:	change to:

Are you currently employed in your licensed profession? ☐ No ☐ Yes; see below.

Supervisor name, title & contact info:	Restrictions on practice:

NARRATIVE: Please feel free to attach further sheets if necessary.

Describe any major changes in your life:

Describe any difficulties you are having following your treatment contract:

Describe what progress you have made over the last quarter:

Can the PSUD assist you in any additional way at this time?

I understand that in submitting this self-report, I give the Massachusetts Professional Recovery System (PSUD) permission to release information regarding my status and participation in PSUD to the therapists, employers and/or physicians named herein.

PSUD Participant Signature Date