Addiction Treatment Questionnaire

TRISTATE HEALTH INC

Name:……

Date:……/……/……

Since last visit did you miss any dosage.? Yes / no

Did you have any triggers to do drugs? Yes / No

Are you attending counseling? Yes /No. If yes, where _____

Do you have any craving? Yes / No.

Did you expose to any drug since last visit? Yes / No.

Did you meet anyone who is doing drugs, since last visit.? Yes/ No.

Did you expose anything that gave you a desire to do drugs, since last visit? Yes/ No.

Are you working? Yes / No. If not, are you disable Yes / No.

If not disable, are you looking for a job? Yes / No.

Dou you have a sponsor who you can talk to in time of crises? Yes / No.

Is your family being aware about your drug treatment? Yes / No

Is your family supporting you in drug treatment? Yes/ No.

Please name one family member who is supporting you in treatment. _____

Do you understand the treatment of addiction? Yes / No.

Do you understand counseling is the part of treatment? / Yes / No.

Please note you are required to bring prove of you counseling to the office and need to have up-to-date with lab. Please also note you may be called for pills counting so you are required to update your contact information on each visit. Failure to comply may lead to discharge from the treatment.