

Name: _____ Date of Birth: ____/____/____ Today's Date: ____/____/____

SUPPLEMENTAL OPIOID ASSESSMENT QUESTIONNAIRE (SOAQ)

The following questions ask for detail about your substance use history and current needs. This information will be used to develop your individualized treatment plan. Please answer each question and return this form to your counselor.

1) At what age did you first use opiates/opioids? _____ years old

2) At what age did your daily or near daily use begin? _____ years old

Check here if not applicable because you have never have been a daily or near daily user

3) Please explain in detail about your past and current use of opiates/opioids.

Opiate/Opioid	Ever Used?		Used in Past Year?	
	Choose Yes or No for each one		Choose Yes or No for each one	
Heroin	Yes	No	Yes	No
OxyContin	Yes	No	Yes	No
OP's (new oxycontin)	Yes	No	Yes	No
Oxycodone	Yes	No	Yes	No
Vicodin	Yes	No	Yes	No
Codeine	Yes	No	Yes	No
Morphine	Yes	No	Yes	No
Dilaudid	Yes	No	Yes	No
Fentanyl	Yes	No	Yes	No
Methadone	Yes	No	Yes	No
Suboxone	Yes	No	Yes	No
Subutex	Yes	No	Yes	No

4) Which of the following CAME FIRST when your regular use of opiates started? (CHECK ONE)

Opiates prescribed for you

Opiates prescribed for someone else that you obtained

Heroin

Other non-prescription opiates

5) What led to your change from one type of opiate to another? (CHECK ALL THAT APPLY)

Did not change

Needed more potent

Depressed

Supplier change

Bored

Cost of drug

Casual offering

Whatever was available

To deal with withdrawal

Change in prescribed drug

Other _____

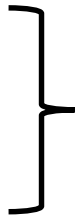
6) How often did you use the drugs below ALONG WITH opiates in the past year?

Mark one in each row for each substance you have used WITH opiates in the past year:						
	Not in Past Year	Once or Twice	About Once Per Month	2-4 Times Per Month	At Least Weekly	Every Day
Cocaine						
Alcohol						
Methadone not prescribed to you						
Suboxone not prescribed to you						
Xanax/Valium						
Butalbital						
Amphetamine						
Marijuana						

7) How much do you use at peak times on a typical day of use?

7a. Use of most frequently taken PILLS at peak times in milligrams per day (CHECK ONE)

- No pill use/not applicable
- Less than 30 mgs.
- 30-60 mgs.
- 60-100mgs.
- 100-160mgs.
- 160-220mgs.
- More than 220 mgs.

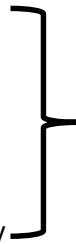


7a-i. Methods of pill use: (CHECK ALL THAT APPLY)

- IV
- Crush & snort
- Oral
- Smoked/laced

7b. Use of HEROIN at peak times, number of times per day on a typical day of use (CHECK ONE)

- No heroin use/not applicable
- Less than once per day
- 1 time per day
- 2 times per day
- 3 times per day
- 4 times per day
- 5 times per day
- More than 5 times per day



7b-i. Methods of heroin use: (CHECK ALL THAT APPLY)

- IV
- Crush & snort
- Oral
- Smoked/laced

8) Estimated Cost and Drug Supply Sources:

8a. What was the estimated cost of your drug habit PER DAY? Amount supplied by:

Legal income \$ _____ + Illegal activity \$ _____ = Total Cost Per Day: \$ _____

8b. How did you obtain your drug supply? (CHECK ALL THAT APPLY)

- | | | |
|--|--|---|
| <input type="checkbox"/> Obtained legally | <input type="checkbox"/> Fraud | <input type="checkbox"/> Paid for it |
| <input type="checkbox"/> Borrow | <input type="checkbox"/> Pawn | <input type="checkbox"/> From family/friends/partner |
| <input type="checkbox"/> Trade | <input type="checkbox"/> Favors | <input type="checkbox"/> Diverted from employer |
| <input type="checkbox"/> Stole/theft/burglary | <input type="checkbox"/> Sold drugs to finance habit | <input type="checkbox"/> Illegal/forged/stolen prescription |
| <input type="checkbox"/> Other, Explain: _____ | | |

9) Please rate your withdrawal when you stop using: (CHOOSE ONE NUMBER)

- | | | | | | | | | | | |
|--------------|----------|------------------------|----------|-----------|----------|---------------------|----------|----------|----------|-----------------------|
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Non-existent | | Bearably uncomfortable | | Difficult | | Extremely difficult | | | | Completely unbearable |

10) What was the longest period you have been abstinent or clean? (CHECK ONE)

- No abstinence → (Go to question #12 if you have not been abstinent)
- Less than 1 week
- 1-4 weeks
- 1-3 months
- 4-6 months
- 6-12 months
- 12 months or longer

11) What were your reasons for relapse after the abstinence? (CHECK ALL THAT APPLY BELOW)

- No abstinence → (Go to question #12 if you have not been abstinent)
- I did not relapse → (Go to question #12 if you did not relapse after your abstinence)

- | | |
|---|---|
| <input type="checkbox"/> Boredom | <input type="checkbox"/> Stress |
| <input type="checkbox"/> Pain | <input type="checkbox"/> I came across some money |
| <input type="checkbox"/> Craving | <input type="checkbox"/> Relationship problems/issues |
| <input type="checkbox"/> Withdrawal | <input type="checkbox"/> Suicidal |
| <input type="checkbox"/> Friends/family using | <input type="checkbox"/> Panic |
| <input type="checkbox"/> Traumatic life event or loss | <input type="checkbox"/> Depressed mood or loneliness |
| <input type="checkbox"/> Medical problem/diagnosis | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Drugs were around/available | <input type="checkbox"/> Other _____ |

12) How many times have you ever overdosed or “fell out”? (defined as non-responsive)

_____ # times (record “zero” if you have never overdosed and go to Question #13)

12a. Have you ever received Narcan/naloxone for an overdose? (CHECK ONE)

No

Yes → For how many of those overdoses did you receive Narcan? _____

→ What is the highest number of doses of Narcan you received during a single overdose episode? _____

13) Have you ever received Opiate Substitute Treatment? [also known as medication assisted treatment or “MAT”]

	Check if MAT Ever	If Yes, Year of Most Recent
Methadone	no yes→	
Suboxone	no yes→	
Subutex	no yes→	
Naltrexone - Oral	no yes→	
Naltrexone - Vivitrol	no yes→	

14) Have you ever received alcohol or drug treatment before?

	Check if Received Treatment Ever	How many times ever?	Year of Most Recent
Inpatient/Residential	no yes→		
Day Treatment	no yes→		
Intensive Outpatient	no yes→		
Outpatient	no yes→		