BAP Wellness
5553 Hwy 90 Pace, FL 32571
Phone: (850) 995-8811
Fax: (850) 995-8810

Call Date: _____

Call Time: _____

PRETREATMENT SCREENING

Completed prior to call

Name: _____

Phone: _____ Best time to contact: _____

Address: _____

_____

DOB: _____ Age: _____ Sex: ( ) M ( ) F

Insurance company: _____ Insurance member no. _____

Do you plan to submit a claim? ( ) No ( ) Yes

Reason for seeking treatment

Substance: _____ How long using? _____

How much? _____ How often? _____

Has your drug use ever resulted in medical or legal problems? ( ) N ( ) Y (Please describe) _____

_____

Have you ever been treated for substance dependence or misuse (eg, detoxification program)? ( ) N ( ) Y

(Please describe setting and length) _____

_____

_____

_____

Have you ever tried to quit on your own? ( ) N ( ) Y (Please describe) _____

_____

Have you ever been treated by a psychiatrist? ( ) N ( ) Y (Please describe treatment reason, setting, and length)

_____

_____

Does anyone in your family (mother, father, brother/sister, child, aunt/uncle, or grandparent) have a history of substance abuse? ( ) N ( ) Y (Please describe) _____

_____

_____

Do you have any medical conditions (eg, diabetes, HIV+, epilepsy, STDs)? ( ) N ( ) Y (Please list all conditions)

_____

_____

Are you currently taking any medication(s) to treat these conditions? ( ) N ( ) Y [Please list medication(s) and dosage(s)] _____

_____

Are you pregnant? ( ) N/A ( ) N ( ) Y ( ) Not Sure

Are there any current legal issues we should be aware of (eg, probation or parole)? ( ) N ( ) Y (Please describe)

_____

Are you currently employed? ( ) N ( ) Y How many hours per week (avg)? _____

Please describe your current living arrangements: _____

_____

_____

Other: _____

_____

_____ Date: _____

Patient Interviewer Signature

Office Assessment

Patient accepted for treatment: ( ) N ( ) Y

If "no"

Describe why: _____

_____

Alternate treatment recommendations:

( ) NA ( ) AA ( ) OTP ( ) Other (list below):

_____

Patient was called to discuss the above: Date _____ Caller Initials _____

If "yes"

Patient was called to schedule first visit: Date _____ Caller Initials _____

First visit requirements discussed with patient:

__ Arrive with full bladder (urine drug screening will be performed)

__ Arrive experiencing moderate opioid withdrawal symptoms (average abstinence periods: methadone or long-acting pain killers–24 hrs; heroin or short-acting pain killers–4 to 6 hrs)

__ Bring ALL medication bottles

__ Bring completed Pretreatment Paperwork or come 30 minutes early

__ Payment will be required in advance

Pretreatment Paperwork explained to patient: Date _____ Caller Initials _____

Pretreatment Paperwork mailed or given to patient: Date _____ Caller Initials _____

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DRUG ABUSE SCREENING TEST (DAST)

1. Have you used drugs other than those required for medical reasons? ( ) Y ( ) N
2. Have you misused prescription drugs? ( ) Y ( ) N
3. Do you misuse more than one drug at a time? ( ) Y ( ) N
4. Can you get through the week without using drugs (other than those required for medical reasons)? ( ) Y ( ) N
5. Are you always able to stop using drugs when you want to? ( ) Y ( ) N
6. Do you misuse drugs on a continuous basis? ( ) Y ( ) N
7. Do you try to limit your drug use to certain situations? ( ) Y ( ) N
8. Have you had "blackouts" or "flashbacks" as a result of drug use? ( ) Y ( ) N
9. Do you ever feel badly about your drug misuse? ( ) Y ( ) N
10. Does your spouse (or parents) ever complain about your involvement with drugs? ( ) Y ( ) N
11. Do your friends or relatives know or suspect you misuse drugs? ( ) Y ( ) N
12. Has drug misuse ever created problems between you and your spouse? ( ) Y ( ) N
13. Has any family member ever sought help for problems related to your drug use? ( ) Y ( ) N

Have you ever:

14. Lost friends because of your use of drugs? ( ) Y ( ) N
15. Neglected your family or missed work because of your use of drugs? ( ) Y ( ) N
16. Been in trouble at work because of drug misuse? ( ) Y ( ) N
17. Lost a job because of drug misuse? ( ) Y ( ) N
18. Gotten into fights when under the influence of drugs? ( ) Y ( ) N
19. Been arrested because of unusual behavior while under the influence of drugs? ( ) Y ( ) N
20. Been arrested for driving while under the influence of drugs? ( ) Y ( ) N
21. Engaged in illegal activities to obtain drugs? ( ) Y ( ) N
22. Been arrested for possession of illegal drugs? ( ) Y ( ) N
23. Experienced withdrawal symptoms as a result of heavy drug intake? ( ) Y ( ) N
24. Had medical problems as a result of your drug use (eg, memory loss, hepatitis, convulsions, or bleeding)? ( ) Y ( ) N
25. Gone to anyone for help for a drug problem? ( ) Y ( ) N
26. Been in hospital for medical problems related to your drug use? ( ) Y ( ) N
27. Been involved in a treatment program specifically related to drug use? ( ) Y ( ) N
28. Been treated as an outpatient for problems related to drug dependence or misuse? ( ) Y ( ) N

Scoring: Each positive response yields 1 point, except for questions 4, 5, and 7 which yield 1 point for a negative response or false direction.

A score greater than 5 requires further evaluation for substance misuse problems.

Skinner HA. The Drug Abuse Screening Test. *Addictive Behavior*. 1982;7(4):363-371.
Yudko E, Lozhkina O, Fouts A. A comprehensive review of the psychometric properties of the Drug Abuse Screening Test. *J Subst Abuse Treatment*. 2007;32:189-198.

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PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ **DATE:** _____

Over the *last 2 weeks,* how often have you been bothered by any of the following problems?
(use "O" to indicate your answer)

	Not at All	Several days	More than half the days	Nearly everyy
1. Little interest or pleasure in doing things				
2. Feeling down, depressed, or hopeless				
3. Trouble falling or staying asleep, or sleeping too much				
4. Feeling tired or having little energy				
5. Poor appetite or overeating				
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down				
7. Trouble concentrating on things, such as reading the newspaper or watching television				
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual				
9. Thoughts that you would be better off dead, or of hurting yourself in some way				
add columns:	+		+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card.) **TOTAL:**

10. If you checked off *any* problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	**Not difficult at all** _____ **Somewhat difficult** _____ **Very difficult** _____ **Extremely difficult** _____

Fold back this page before administering this questionnaire

INSTRUCTIONS FOR USE

for doctor or healthcare professional use only

PHQ-9 QUICK DEPRESSION ASSESSMENT

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment on accompanying tear-off pad.
2. If there are at least 4 ✓s in the blue highlighted section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.
3. ***Consider Major Depressive Disorder***
   —if there are at least 5 ✓s in the blue highlighted section (one of which corresponds to Question #1 or #2)

   Consider Other Depressive Disorder
   —if there are 2 to 4 ✓s in the blue highlighted section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician and a definitive diagnosis made on clinical grounds, taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient. Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✓s by column. For every ✓: Several days = 1 More than half the days = 2 Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying PHQ-9 Scoring Card to interpret the TOTAL score.
5. Results may be included in patients' files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

PHQ-9 SCORING CARD FOR SEVERITY DETERI

for healthcare professional use only

Scoring— add up all checked boxes on PHQ-9

For every ✓: Not at all = 0; Several days = 1;
More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

Total Score	Depression Severity
0-4	None
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

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QUALITY CARE THERAPY PROGRESS REPORT (Adapted from Subjective Opiate Withdrawal Scale)

Instructions:

- Patient fills out "COMPLETED BY PATIENT" section and brings form to counselor
- Counselor fills out and signs "COMPLETED BY COUNSELOR" section and returns form to patient
- Patient brings form to physician. Physician fills out "COMPLETED BY PHYSICIAN" section and files with patient records

Patient Name _____ Medication dose _____ mg/day Date _____

COMPLETED BY PATIENT

Circle the answer that best fits the way you feel now

	Not at all				Extremely
I feel anxious	0	1	2	3	4
I feel like yawning	0	1	2	3	4
I am perspiring	0	1	2	3	4
My nose is running and/or my eyes are watery	0	1	2	3	4
I have goosebumps and/or chills	0	1	2	3	4
I feel nauseated or like I may need to vomit	0	1	2	3	4
I have stomach cramps and/or diarrhea	0	1	2	3	4
My muscles twitch	0	1	2	3	4
I feel dehydrated and/or have not had much appetite	0	1	2	3	4
I am having difficulty sleeping	0	1	2	3	4
I have a headache	0	1	2	3	4
My muscles and bones ache	0	1	2	3	4
I feel like using right now	0	1	2	3	4
I would rate my overall level of withdrawal as	0	1	2	3	4
Do you feel you need a dosage change?		☐ No	☐ Yes	☐ Up	☐ Down
Have you used alcohol or other drugs since your last visit?		☐ No	☐ Yes		
If "yes," please describe what, when, and how much					

Handelsman L, Cochrane KJ, Aronson MJ, Ness R, Rubinstein KJ, Kanof PD. (1987). Two new rating scales for opiate withdrawal. *Am J Drug Alcohol Abuse*. 13(3):293-308.

Please describe any life changes, triggers, or stressors that have occurred since your last visit.

COMPLETED BY PATIENT

List your ideas and plan to cope with these life changes, triggers, or stressors.

What are the new skills you learned in counseling since your last appointment?

Have you applied these new skills in your life? If yes, are they helping?

What is your next short-term goal?

COMPLETED BY COUNSELOR

How often has the patient been attending counseling?

Describe the patient's progress since his or her last doctor's appointment.

Counselor signature _____ Date _____

Telephone number _____

S/O)	
A)	P)

COMPLETED BY PHYSICIAN

Other medical conditions that need treatment?

Dose adjustment necessary? ☐ N ☐ Y New dose _____

Other medications necessary? ☐ N ☐ Y (list)

Is the patient receiving the psychosocial support considered necessary? ☐ N ☐ Y

Do the benefits of treatment outweigh the risks of accidental overdose, misuse, and abuse? ☐ N ☐ Y

Is the patient making adequate progress toward treatment goals? ☐ N ☐ Y