PATIENT DEMOGRAPHIC INFORMATION / DAYTON PAIN CENTER, LLC. / WRIGHT PATH RECOVERY

Patient Name: _____ SSN#: _____-_____-_____ DOB: _____/_____/19____

Sex: M / F Address: _____ City: _____OH Zip: _____

Home Tel #: _____ Work Tel #: _____ Cell Tel # _____

E Mail : _____ Profession: _____

Employer/Address: _____ City: _____ State: _____ Zip: _____

Marital Status: Single / Married / Widowed Family Doctor: _____ Tel # _____Fax_____

Spouse's Name: _____ Spouse's SSN#: _____/_____/_____

Spouse's Employer: _____ Spouse's Employer Tel #: _____

Spouse's Emp. Address: _____ City: _____ OH Zip: _____

Who may we thank for referring you to us: _____ Tel #: _____

Referring Physician Name: _____ Tel #: _____Fax # _____

Ref Physician Address: _____ City: _____ OH Zip: _____

Reason for Referral: _____

In case of emergency who may we contact: _____ Tel # _____

Is this visit due to injury: Yes / No Type of injury: Auto / BWC_____

Nearest relative not living with you: _____ Tel # _____

Nearest friend not living with you: _____ Tel # _____

Landlord Name: _____Tel # _____

INSURANCE INFORMATION Financial Responsible party for billing _____

Insurance Name: _____ Policy # _____ Group # _____ ID # _____
Address: _____ City: _____ State: _____ Zip: _____
Tel # _____Insured Name: _____ SS# _____
Secondary Insurance: _____ Policy # _____ Group # _____ ID # _____
Address: _____ City: _____ State_____ Zip _____
Tel # _____Insured Name : _____ SS # _____
Workers Compensation: Company: _____Address: _____
Telephone # _____ Claim # _____ Date Of Injury: ____/_____/_____Case worker_____

AUTHORIZATION: I hereby authorize DAYTON PAIN CENTER, LLC. to release any information concerning my illness and treatments and that of my dependents. I also authorize payment of medical benefits of DPC for services rendered. I understand and agree (regardless of my status) that I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this sheet and have completes all the answers. I CERTIFY this information is true and correct to the best of my knowledge. I will notify any changes in my status or the above information

Responsible party Signature: _____ Date: _____/_____/2017

Krishna B. Reddy , MD., S. Erragolla, MD; L. Mathai, MD; J. Gouda, MD; D. McClure, MD; S. Singh, MD S. Mathai. MD., Vraj Chauhan, PhD, LPCC., Jennifer Walters., Randy Young, LCDC III., C. Cantelupe, CDCA II., K. Haney, LCDC III
Wright path Recovery/ Dayton Pain Center

PATIENT TREATMENT CONTRACT

Patient Name _____ **Date** _____/_____/2017

As a participant in buprenorphine treatment for opioid misuse and dependence, I freely and voluntarily agree to accept this treatment contract as follows:

1. I agree to keep and be on time to all my scheduled appointments.
2. I agree to adhere to the payment policy outlined by this office.
3. I agree to conduct myself in a courteous manner in the doctor's office.
4. I agree not to sell, share, or give any of my medication to another person. I understand that such mishandling of my medication is a serious violation of this agreement and would result in my treatment being terminated without any recourse for appeal.
5. I agree not to deal, steal, or conduct any illegal or disruptive activities in the doctor's office.
6. I understand that if dealing or stealing or if any illegal or disruptive activities are observed or suspected by employees of the pharmacy where my buprenorphine is filled, that the behavior will be reported to my doctor's office and could result in my treatment being terminated without any recourse for appeal.
7. I agree that my medication/prescription can only be given to me at my regular office visits. A missed visit may result in my not being able to get my medication/prescription until the next scheduled visit.
8. I agree that the medication I receive is my responsibility and I agree to keep it in a safe, secure place. I agree that lost medication will not be replaced regardless of why it was lost.
9. I agree not to obtain medications from any doctors, pharmacies, or other sources without telling my treating physician.
10. I understand that mixing buprenorphine with other medications, especially benzodiazepines (for example, Valium®*, Klonopin®†, or Xanax®‡), can be dangerous. I also recognize that several deaths have occurred among persons mixing buprenorphine and benzodiazepines (especially if taken outside the care of a physician, using routes of administration other than sublingual or in higher than recommended therapeutic doses).
11. I agree to take my medication as my doctor has instructed and not to alter the way I take my medication without first consulting my doctor.
12. I understand that medication alone is not sufficient treatment for my condition, and I agree to participate in counseling as discussed and agreed upon with my doctor and specified in my treatment plan.
13. I agree to abstain from alcohol, opioids, marijuana, cocaine, and other addictive substances (excepting nicotine).
14. I agree to provide random urine samples and have my doctor test my blood alcohol level.
15. I understand that violations of the above may be grounds for termination of treatment

_____ _____ Date _____/_____/2017
Patient Signature Witness Co signature

Comment [DR1]:

Krishna B. Reddy , **MD.; S. Erragolla, MD; L. Mathai, MD; P. J. Gouda, MD; D. McClure, MD; S. Singh, MD., S. Mathai, MD.,**
Dayton Pain Center/Wright Path Recovery

Patient's Rights

Patient Name_____**Date**_____/_____/2017

1. The right to be treated with consideration and respect for personal dignity, autonomy and privacy;
2. The right to reasonable protection from physical, sexual or emotional abuse and inhumane treatment;
3. The right to receive services in the least restrictive, feasible environment;
4. The right to participate in any appropriate and available service that is consistent with an individual service plan (ISP), regardless of the refusal of any other service, unless that service is a necessity for clear treatment reasons and requires the person's participation;
5. The right to give informed consent to or to refuse any service, treatment or therapy, including medication absent an emergency;
6. The right to participate in the development, review and revision of one's own individualized treatment plan and receive a copy of it;
7. The right to freedom from unnecessary or excessive medication, and to be free from restraint or seclusion unless there is immediate risk of physical harm to self or others;
8. The right to be informed and the right to refuse any unusual or hazardous treatment procedures;
9. The right to be advised and the right to refuse observation by others and by techniques such as one-way vision mirrors, tape recorders, video recorders, television, movies, photographs or other audio and visual technology. This right does not prohibit an agency from using closed-circuit monitoring to observe seclusion rooms or common areas, which does not include bathrooms or sleeping areas;
10. The right to confidentiality of communications and personal identifying information within the limitations and requirements for disclosure of client information under state and federal laws and regulations;
11. The right to have access to one's own client record unless access to certain information is restricted for clear treatment reasons. If access is restricted, the treatment plan shall include the reason for the restriction, a goal to remove the restriction, and the treatment being offered to remove the restriction;
12. The right to be informed a reasonable amount of time in advance of the reason for terminating participation in a service, and to be provided a referral, unless the service is unavailable or not necessary;
13. The right to be informed of the reason for denial of a service;
14. The right not to be discriminated against for receiving services on the basis of race, ethnicity, age, color, religion, gender, national origin, sexual orientation, physical or mental handicap, developmental disability, genetic information, human immunodeficiency virus status, or in any manner prohibited by local, state or federal laws;
15. The right to know the cost of services;
16. The right to be verbally informed of all client rights, and to receive a written copy upon request;
17. The right to exercise one's own rights without reprisal, except that no right extends so far as to supersede health and safety considerations;
18. The right to file a grievance;
19. The right to have oral and written instructions concerning the procedure for filing a grievance, and to assistance in filing a grievance if requested;
20. The right to be informed of one's own condition; and,
21. The right to consult with an independent treatment specialist or legal counsel at one's own expense.

Provisions of client rights;
1. Wright Path Recovery will explain and maintain documentation in the clients' record regarding the explanation of rights to each person served prior to or beginning assessment of treatment services.
2. In a crisis or emergency, the client will be given verbal pertinent rights such as consent to treat, right to refuse treatment and consequences of that consent or refusal. Full clients' rights will be provided at subsequent, non-emergent meetings.
3. Clients or recipients of information and referral services, consultation services, mental health education service, and prevention service will be provided a copy of the client rights policy upon request.
4. Explanation of rights will be in a manner appropriate for the person's understanding.

_____ _____

Patient's Signature

Drs. S. Erragolla, B. Reddy, L. Mathai,, S. Singh, D. McClure, S. Mathai, J. Gouda, I. Reddy
Dr. Vrajlal Chauhan, PhD, LPCC, Jennifer Walters, R. Young, Sophie

Krishna B. Reddy , MD., S. Erragolla, MD; L. Mathai, MD; J. Gouda, MD; D. McClure, MD; S. Singh, MD S. Mathai. MD., Vraj Chauhan, PhD, LPCC., Jennifer Walter, LISW.S., Randy Young, LCDC III., C. Cantelupe, CDCA II.,
Wright path Recovery/ Dayton Pain Center

PATIENT TREATMENT CONSENT FOR SUBSTANCE USE DISORDERS

We the physicians/Couselors at Dayton Pain Center which include Dr. Srinivas Erragolla, Dr. Krishna B. Reddy, Dr. Lita Mathai, Dr. Jan Gouda, Dr. Dennis McClure, Dr. Steven Mathai, Dr. Simer Singh, and Dr. I. Reddy will be providing the care. You will also be seen by the counselors under the leadership of Dr. Vraj Chauhan, which include Randy Young and Carrissa Guadeloupe. We would like you to be familiar with the following procedures, confidentiality laws, precautions, rights and responsibilities as well as safety instructions:

1. **Expectations:** Just like you expect us provide care during your recovery we expect you to abide by the policies and procedures for safe recovery.
2. **Dress code:** You should be dressed appropriately when you come to see your physician at the Dayton Pain Center.
3. **Conversations:** We would like you to minimize the conversations with other patients only to the non-medical and non-medications topics.
4. **Pill counts:** Periodically you may be called to ensure proper utilization and use of prescribed medications. Failure to respond to the pill count can potentially result in serious consequences including discharge.
5. **Urine Drug Screen**: Drug testing is a part of recovery program not necessarily to punish but to assure that the medication is taken in a proper fashion according to the prescription and instructions.
6. **Drug & Metabolite:** It is absolutely necessary to see the medication and break down products in your urine before any prescription can be issued. This is also a requirement for the insurance authorization.
7. **Adulteration:** Adulteration of the urine specimen and the lack of medication in the urine specimens as well as the lack of metabolites can lead to serious consequences including discharge.
8. **Federal Confidentiality:** We would like to maintain confidentiality of your illness with the exception of child abuse, communicable diseases, requiring attention and treatment, and any violence or misbehavior in the premises.
9. **Primary Care:** Every patient need to have a primary care provider once they are enrolled in our program in order to receive treatment at our facility.
10. **Medication education** will be provided through your physician/counselor. In order to assure proper concentration of the medication and proper level of medication in your blood, the medication has to be taken exactly as prescribed. Failure to do so can result in the reduced levels in your urine or lack of levels of medications in your urine leading to serious consequences.
11. **Attendance** at NA or AA or other 12-step group meetings is essential along with the sponsor. Please provide us with the place of 12-step facility as well as the name of the sponsor and your sponsor's telephone number.
12. **Information:** Update the personal information, which does include most current telephone number, address, and the latest insurance information. This is necessary for mediation authorization, calling for pill counts & schedule changes due to physicians going on vacations.
13. **Evaluation & Frequency:** Initially you will be evaluated more frequently by the counselors to assess the stages of your change, severity of illness, and your recovery attitude. This will help your MD to determine the type of treatment and the level of care you will need. This may take roughly five to six sessions which means that you will be asked to come to our clinic at a minimum of thrice a week for three weeks. Following this you will be seen once a week. We would like you to come down to one Buprenorphine 8 mg before consideration is given for Bi-Weekly Office Visits.
14. **Personal Information:** We would like you to keep your medical information personal and would request you not to divulge about your prescriptions or your other medical conditions with other patients.
15. **Risk of serious side effects**: of slow shallow breathing, drowsiness, arrest or cessation of breathing, can result with the combination of buprenorphine with the illicit usage of other substances like benzodiazepines (Xanax, Valium, Ativan, and Klonopin).

16. **Surgery/other Painful conditions:** If you require any surgery by any other doctor/dentist, please inform your provider of the medications and type of treatment you are undergoing through our office so that their own prescription would not create side effects or serious withdrawal reactions. Most of the minor surgeries do not require additional medications as the Buprenorphine it by self is 8 times stronger than morphine for pain relief. Please inform your provider or call and inform the MA staff so that you will not be in violation of the rules as any other prescriptions with-out proper authorizations are considered illegal that can result in dismissal.
17. **Appointments:** It is important to keep your appointment as **your provider is the only provider who can give you the Suboxone** and other providers will not give you any prescriptions due to the limitations of the number of patients each provider can treat. Each MD sees their suboxone patients on a designated day and time. Some days your MD may be working in our other offices and may not be available.
18. **Most Dangerous Period:** Relapse following a period of abstinence from drug use results in death due to loss of tolerance. Use of medication and slow titration over long period with change in life style prevent this danger.

19. **Treatment of other dependencies:** Abstain from all other illicit substances including smoking is recommended to prevent relapse as all these other substances work at the same brain centers and feed the habit and relapse.
20. **Disease:** Drug addiction is a complex illness and a brain disease affecting multiple circuits including reward, motivation, learning, memory and loss of inhibitory control over behavior. Remaining in treatment for a longer period is critical, medication alone is ineffective without commitment, 12 step meetings and counseling. Medication assisted detoxification is only the first step.
21. **Avoid:** Please do not bring children or any drinks including water, coke, pop or coffee to the office.
22. **Bringing Bottles empty foils:** You are required to bring all the empty foils & bottles at each office visit.
23. **Destruction of unused medications:** Do not flush the medications or discard them on your own. They should be verified documented before they are disposed, in front of the staff by the patient. You witness the disposal by staff.
24. **Refills:** Lost or stolen controlled medications will not be replaced.
25. **Never:** take more than prescribed. It is OK to try less to see how you do with lower dose, remember that you will be tested for presence of medications in your urine. Using more than prescribed can result in shortage prior to the office visit and can be questioned for selling or diversion. If you continue to have craving discuss with your provider so that other alternative remedies can use used by your provider.
26. **Single Pharmacy:** You agree to use single pharmacy, single physician & abstain from alcohol, opioids, MRJ, cocaine & other addictive substances.
27. **Federal Confidentiality Laws:** Patient's commission of crime on the premises or against employees or in case of child abuse is not protected by federal law and your rights.
28. **Child Abuse:** Suspected Child abuse & neglect made under state law will be reported to the State or Local authorities.
29. **Medical records:** Patients will have opportunity to inspect and copy their records. Disclosure of information may be permitted in Emergency or committing theft on the premises
30. **Criminal Justice:** Disclosure to Criminal justice in connection with their duty to monitor the patient's progress.
31. **Information to Patient:** Patient's rights, conduct & responsibilities, payment policies, fees for services, provision for after hour and emergency care, patient's rights to refuse to participate in experimental research, advance directive were provided.
32. **It is the patient's responsibility to make the payments at the time of service.** Separate copay will apply to counseling, Urine Drug screens and Office visits. Failure to make payments could result in dismissal.
33. **Treatment Agreement:** By signing below the patient agree to abide by the above guiding principles for good recovery and understand that violations may be grounds for termination of treatment.
34. **Expectations of the client:** Patient is expected to be on time for the Office visits, must meet 2- per week of group meeting have sponsor and maintain a sober environment, and consequences if client does not meet expectations.
35. **Consequences:** There consequences if client does not meet the expectations which does include but not limited to frequency of visits, witnessed drug testing, contingency management, reduction & or withdrawal of medications, 30 day notice of behavior modification, discharge & notification to the legal system if found to be tampering or involved in illegal activities.
36. **Service fees:** Initial Evaluation fee of $ 300 with follow up evaluation fee of $ 110 established low moderate and $ 160 for established high moderate complexity. There will be an additional charge for the counseling services.
37. **Individual's responsibility:** it is the responsibility of the client to pay for the services rendered**.** Non-payment will result in discharge from the clinic.
38. **Clients receipt of this agreement:** Client acknowledges the receipt of a copy of this agreement along with patient's rights document(42C.F.R.), consents and agreed to abide by the conditions set forth in this agreement.
39. □ **Refusal to consent:** I refused to sign this Agreement / Consent.
40. □ **Withdrawal of consent:** I am withdrawing this consent and previously signed consent by checking the box.
41. Acknowledge the receipt of the federal laws and regulations that indicate the confidentiality of client records are protected as required by 42 C.F.R. part B, Paragraph 2.22

_____ _____ _____/_____/2017

Patients signature Dayton Pain Center & Your Providers Date

Drs. S. Erragolla, K. Reddy, L. Mathai, J. Gouda, D. McClure, S. Singh, S. Mathai, I. Reddy

_____ Dr. Chauhan, PhD, LPCC, J. Walter, LISW.S, R. Young, C. Cantelupe,

Print Patients Name

Krishna Reddy , MD., S. Erragolla, MD, L. Mathai, MD, J. Gouda,, MD: S. Singh, MD; D. McClure, MD., S. Mathai, MD
Dayton Pain Center/Wright Path Recovery

Patient Intake OUD History

Patient Name:_____ Date: _____/_____/2017

Family Physician: _____ Date of Last Physical: _____/_____/201_____

What is your transportation to the office: Car / Insurance Taxi / Family, Friends / Car pooling / Bus Transportation

Current or past Medical / Dental Hx (Check all that apply): □ Asthma □ Hypertension □ Pancreatic Problems □ Thyroid

□ Hepatitis □ GI Disease □ Head Trauma □ Diabetes □ HIV/ AIDS □ Abnormal Pap smear □ Anemia □ Heart □ Epilepsy

□ Sexual Transmitted □ Burn Injuries □ Rheumatological conditions □ Neuropathy □ Hepatitis C □ Dental problems

History of automobile accidents? □ None □ Major accidents □ Thunder benders _____

History of Head Trauma: □ None □ Yes _____

Physical disabilities: □ Back □ Lung □ Heart □ Trauma □ HIV □ Hepatitis □ Morbid Obesity □ Gastric bypass _____

Your current problem?(Drug):_____

Precipitating initial cause? □ drug availability □ Teen age adventure □ Bad company □ Family usage □ Lack of parental control

□ Anxiety / Depression □ Peer substance use □ Spousal / other half drug use □ Chronic Pain □ Unresolved Medical conditions

First use of smoking MRJ alcohol drugs (Age): _____

When did it become a regular Habit? _____

Family & significant other History of addiction: _____

_____

Family / significant other Mental history: _____

Family Medical History: □ Diabetes □ Cancer □ Heart Dis □ COPD □ Kidney □ Other _____

Early childhood growth precipitating factors: □ Child abuse □ family dysfunction □ working parents □ Family drug use

Early onset of mood, anxiety or ADD & their treatment with medications? □ No □ Yes □physical abuse □Divorced parents

□ Emotional abuse □ Single parent □Poor Neighborhood □ Prenatal drug exposure _____

_____

Medications include the Over the counter (OTC) & Energy drinks (ED):

Drug	Current dose	Duration	Drug	Current dose	Duration
OTC			**ED**		

Allergies(Medications, Food, Environmental, Latex) & what kind of reaction?

Medication/Allergen	Drug, Food, Environmental, Latex	What kind of reaction you have?
Drug		**□ None □ Rash □ Vomiting □ Itching**
Drug & Drugs		**□ None □ Rash □ Nausea □ Itching**
Environmental(Dust, Pollen)		**□ None □**
Food & Foods		**□ None □**
Latex		**□ None □**

Drug or Alcohol treatment (IP & OP) Name, City & year: _____

Why Relapse / Reason for Failure: _____

Surgical History? □ None □ Back □ Knee □ Hernia □ Gall bladder □ Multiple Gyn procedures □ Gastric Bypass □ Shoulder □ Hip

Ethnic Cultural influences: □ None _____

Have you been diagnosed with a psychiatric or mental illness (Include the Medications)? □ Bipolar □ Anxiety □ PTSD □ Panic

□ Depression □ ADHD □ Panic _____

Psychiatric Meds Rx: _____

_____

Previous Treatments, Hospitalization, recovery centers (Names): _____

Psychiatrist / MD: □ None □ Name _____ Phone # _____ Fax # _____

Any thoughts of □ Self Harm □ Suicide thoughts □ Ideation □ Harming others □ Intent with out plan □ Attempt with Plan _____

Marriage/Spouse/Partner? □ Married □ Single □ Separated □ Divorced □ Pending in the court □ Trying to work out _____

Children/Sex/Ages any addiction in them? _____

Sexual Orientation: □ Hetero □ Homo □ Bisexual □ Partners Name _____

Sexual Practice: □ Loss of Interest □ Safe Sex □ Random □ Impulsive □ Monogamous □ Condom Use □ Birth control Pills/Vasectomy

□ Separation from Partner □ Single Divorce □ Selling sex for Drugs □ Contacting Sexually Transmitted Diseases _____

Indication of Sexual Abuse & Neglect? □ None □ Raped □ Abusive Partner □ Domestic Violence _____

Maladaptive Problem Behavior: □ None □ Self Harm □ Aggressive Behavior □ Attention Seeking □ Tantrum Behavior _____

Have You ever Overdosed (How many times): _____

Do have a sponsor? (Name & Tel No): _____

Do you go to the Group Meetings, Where, How often: _____

Your Longest Period of Abstinence: _____

Religion/Spirituality:□Non-Believer □ Believer Religion □ None □ Christian □ Baptist □ Methodist □ Lutheran □ Pentecostal □ Catholic

Are you going to use your faith to overcome addiction: □ No □ Yes How or Why not?_____

Strengths & Assets: □ Family □ Spousal support □ Job Income □ Transportation □ Place to live □ Determined honest commitment

Weakness & limitation: □ Transportation □ Housing □ Lack of skills □ Environment □ Family □ Cannot commit □ No Support

Age & Illicit Substance use sequence: _____

Substance Use History	No	Yes / Past / Now	IV / Snorting / Oral	How Much	How Often	Quantity Last Used
Smoking /Nicotine	N0	Yes / Past / Now	Inh / Snuff /Chew			
Alcohol	No	Yes / Past / Now	IV / Snorting / Oral			
Marijuana	No	Yes / Past / Now	IV / Snorting / Oral			
Inhalants	No	Yes / Past / Now	IV / Snorting / Oral			
Pain Pills/Methadone	No	Yes / Past / Now	IV / Snorting / Oral			
LSD/Hallucinogens	No	Yes / Past / Now	IV / Snorting / Oral			
Cocaine	No	Yes / Past / Now	IV / Snorting / Oral			
Heroin	No	Yes / Past / Now	IV / Snorting / Oral			
Stimulants	No	Yes / Past / Now	IV / Snorting / Oral			
Tranquilizers	No	Yes / Past / Now	IV / Snorting / Oral			

Sleeping pills	**No**	**Yes / Past / Now**	**IV / Snorting / Oral**			
Crystal Meth	**No**	**Yes / Past / Now**	**IV / Snorting / Oral**			
Ecstasy	**No**	**Yes / Past / Now**	**IV / Snorting / Oral**			
Adderall/Ritalin	**No**	**Yes / Past / Now**	**IV / Snorting / Oral**			
Bath Salts	**No**	**Yes / Past / Now**	**IV / Snorting / Oral**			

Social Problems: □ None □ Loss of friends □ Strained family relationship □ Lacks support from partner □ Lack of social skills □ Isolation

Leisure & Recreation: □ None □ Minimal □ Work □ Family care □ Sports □ Movies □ Gardening □ Drug procuring □ Other_____

Educational History: □ High School Drop-out □ Diploma □ GED □ Tech School □ Some College

Current Employer (Name address): _____

Prior work History (Where How long, reason to quit): _____

What effect drugs played with work? _____

Financial Status: □ State assistance □ Waitress □ Painting □ House-keeping □ Labor □ Office Work □ _____

Monthly Income? _____ **Work Shift:** □ 7-3 □ 3-11 □ 11-7 **Ability to come for Rx?** _____

Military Service? □ Yes □ No □ Branch _____ **How Long?** _____**Yrs Discharged** □ Honorable □ Dishonorable_____

Legal History Pending Charges & Parole/Probation Status: □ None □ Yes □ DWI □ Domestic Violence □ Drug related

If Yes Parole officer name, Court, Fax # & Phone # _____

History of Jail or Prison & Offense: _____

Other Legal Assessment: □ Children's Services □ Child support Enforcement □ Restriction of Movement _____

How did Addiction Affect Legal issues? □ Selling of Drugs Stealing to maintain drugs _____

Did you try to stop using drugs on your own & How long? □ No □ Yes □ ___Months _____

What type of treatment worked best for you? _____

Do you believe in higher spirit/God/Power / Faith higher than you & will seek such help: □ No □ Yes _____

Will you seek help from Priest / Rabi / Church / God / Higher spirit? □ No □ Yes _____

Are committed not to provide the urine samples with-out tampering? □ No □ Yes _____

Are you committed to keep your medications safe with-out loosing and safely away from children? No □ Yes _____

Vocational Assessment: □ Looking for a job □ Looking for a place to live □ Trying to improve the skills □ Trying to improve lost relationship □ Living arrangement □ Home & Financial management

Response to previous treatments? □ No previous treatments □ Good Response

_____ _____

Patients signature **S. Erragolla/B. Reddy/L. Mathai/S. Singh/J. Gouda/S. Mathai/D. McClure**
Jason/Cuck/Darsey/Annette/Ramsey/Annette/

BRIEF MICHIGAN ALCOHOL SCREENING TEST
(MAST)

Patient Name:_____ Date: _____/_____/2017

	YES	NO	POINTS
1. Do you feel you are a normal drinker? *	YES	NO	2
2. Do friends or relatives think you are a normal drinker ?*	YES	NO	2
3. Have you ever attended a meeting of Alcoholics Anonymous?	YES	NO	2
4. Have you ever lost friends or girlfriends/boyfriends because of drinking?	YES	NO	2
5. Have you ever gotten into trouble at work because of drinking?	YES	NO	2
6. Have you ever neglected your obligations, your family, or your work for 2 or more days in a row because you were drinking?	YES	NO	2
7. Have you ever had delirium tremens (DTs), severe shaking, heard voices, seen things that weren't there after heavy drinking	YES	NO	2
8. Have you ever gone to anyone for help about your drinking?	YES	NO	2
9. Have you ever been in a hospital because of drinking?	YES	NO	5
10.Have you ever been arrested for drunk driving or driving after drinking?	YES	NO	5
TOTAL SCORE			

Negative responses are alcoholic responses.

Scoring

- < 3 points, nonalcoholic
- 4 points, suggestive of alcoholism
- 5 or more, indicates alcoholism

1. Selzer ML. The Michigan Alcoholism Screening Test: The quest for a new diagnostic instrument. *American Journal of Psychiarty* 27(12): 1653-1658, 1971. **2.** Pokorny AD; Miller BA; Kaplan HB. The Brief MAST: A shortened version of the Michigan Alcoholism Screening Test.*American Journal of Psychiatry* 129(3): 342-345, 1972.

Krishna B. Reddy , MD.; S. Erragolla, MD; L. Mathai, MD; J. Gouda, MD; D. McClure, MD; S. Singh, MD., S. Mathai, MD.,
Dayton Pain Center/Wright Path Recovery

DRUG ABUSE SCREENING TEST (DAST)

Patient Name:_____ Date: _____/_____/2017

		Yes	**No**
1.	Have you used drugs other than those required for medical reasons?	**Yes**	**No**
2.	Have you misused prescription drugs?	**Yes**	**No**
3.	Do you misuse more than one drug at a time?	**Yes**	**No**
4.	Can you get through the week without using drugs (other than those required for medical reasons ?	**Yes**	**No**
5.	Are you always able to stop using drugs when you want to?	**Yes**	**No**
6.	Do you misuse drugs on a continuous basis?	**Yes**	**No**
7.	Do you try to limit your drug use to certain situations?	**Yes**	**No**
8.	Have you had "blackouts" or "flashbacks" as a result of drug use?	**Yes**	**No**
9.	Do you ever feel bad about your drug misuse?	**Yes**	**No**
10.	Does your spouse (or parents) ever complain about your involvement with drugs?	**Yes**	**No**
11.	Do your friends or relatives know or suspect you misuse drugs	**Yes**	**No**
12.	Has drug misuse ever created problems between you and your spouse?	**Yes**	**No**
13.	Has any family member ever sought help for problems related to your drug use?	**Yes**	**No**

Have you Ever:

15.	Neglected your family or missed work because of your use of drugs?	**Yes**	**No**
16.	Been in trouble at work because of drug misuse?	**Yes**	**No**
17.	Lost a job because of drug misuse?	**Yes**	**No**
18.	Gotten into fights when under the influence of drugs?	**Yes**	**No**
19.	Been arrested because of unusual behavior while under the influence of drugs?	**Yes**	**No**
20.	Been arrested for driving while under the influence of drugs?	**Yes**	**No**
21.	Engaged in illegal activities to obtain drugs?	**Yes**	**No**
22.	Been arrested for possession of illegal drugs?	**Yes**	**No**
23.	Experienced withdrawal symptoms as a result of heavy drug intake?	**Yes**	**No**
24.	Had medical problems as a result of your drug use (eg, memory loss, hepatitis, convulsions, bleeding	**Yes**	**No**
25.	Gone to anyone for help for a drug problem?	**Yes**	**No**
26.	Been in hospital for medical problems related to your drug use?	**Yes**	**No**
27.	Been involved in a treatment program specifically related to drug use?	**Yes**	**No**
28.	Been treated as an outpatient for problems related to drug dependence or misuse	**Yes**	**No**

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* 7(4): 363-371, 1982.

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Patient Name:_____ Date: _____/_____/2017

DSM-V CRITERIA FOR OPIOID DEPENDENCE DIAGNOSIS: WORK SHEET

Diagnostic Criteria* (Dependence requires meeting 3 or more criteria)	Meets criteria Yes	No	Notes/supporting information
(1) ****Tolerance**, as defined by either of the following: (a) Need higher dose over time to achieve desired effect or intoxication	**Yes**	**No**	
(b) Markedly diminished effect with time			
(2) ****Withdrawal**, as manifested by either of the following: (a) the characteristic withdrawal syndrome	**Yes**	**No**	
(b) Opioids **used to avoid withdrawal symptoms**	**Yes**	**No**	
(3) Opioids are often taken in larger amounts or over longer period of time than intended.			
(4) There is a **persistent desire or unsuccessful efforts** to cut down or control opioid, use.	**Yes**	**No**	
(5) A **great deal of time is spent in activities necessary to obtain the opioid**, use the opioid, or recover from its effects.	**Yes**	**No**	
(6) **Craving**, or strong desire to use opioids	**Yes**	**No**	
(7) **Recurrent opioid use resulting in failure to fulfill major role obligations** at work, school or home			
(8) **Continued opioid use despite having persistent or recurrent social or interpersonal problems** caused or exacerbated by the effects of opioids	**Yes**	**No**	
(9) Important **social, occupational or recreational activities are given up** or reduced because of opioid use.	**Yes**	**No**	
(10) **Recurrent opioid use in situations in which it is physically hazardous**	**Yes**	**No**	
(11) **Continued use** despite knowledge of having a persistent **or recurrent physical or psychological problem** that is likely to have been caused or exacerbated by opioids	**Yes**	**No**	
	Total Score		

** This criteria is not considered to be met for those individuals taking opioids solely under appropriate medical supervision

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Becks Anxiety Inventory (BAI)

Patients Name: _____ Date: _____/_____/2017

Below is a list of common symptoms of anxiety. Please carefully read each item in the list. Indicate how much you have been bothered by each symptom during the PAST WEEK, INCLUDING TO DAY. by circling the number in the corresponding space in the column next to each symptom.

	Not At All	Mildly It did not bother me much	Moderately it was very unpleasant but I could stand it	Severely I could barely stand it
1. Numbness or tingling	0	1	2	3
2. Feeling Hot	0	1	2	3
3. Wobbliness of Legs	0	1	2	3
4. Unable to relax	0	1	2	3
5. Fear of the worst happening	0	1	2	3
6. Dizzy or lightheaded	0	1	2	3
7. Heart pounding or racing	0	1	2	3
8. Unsteady	0	1	2	3
9. Terrified	0	1	2	3
10. Nervous	0	1	2	3
11. Feeling pf chocking.	0	1	2	3
12. Hands trembling	0	1	2	3
13. Shaky	0	1	2	3
14. Fear of losing control	0	1	2	3
15. Difficulty breathing	0	1	2	3
16. Fear of Dying	0	1	2	3
17. Scared	0	1	2	3
18. Indigestion or discomfort in abdomen	0	1	2	3
19. Faint	0	1	2	3
20. Face Flushed	0	1	2	3
21. Sweating (Not due to heat)	0	1	2	3
Total Each column	0			
Total of all columns				

Low Anxiety: 1-21 Moderate Anxiety: 22-35 High Anxiety: 36 or above

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Patient Health Questionnaire (PHQ-9) (Depression)

Patients Name: _____ **Date:** _____/_____/2017

Over the last 2 weeks how often you have been bothered by any of the following problems?	Not at all (0)	Several Days(1)	More than half the days (2)	Nearly Every Day(3)
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling / staying asleep, sleep too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself or that you are a failure or have let yourself or your family	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching the television	0	1	2	3
8. Moving or speaking so slowly that other people could have notified. Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way.	0	1	2	3
	Not difficult at all	Some what difficult	Very difficult	Extremely difficult
10. If you checked off any problem on this questionnaire so far, 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?	0	1	2	3
Total Score Each Column	0			
Total of All Columns				

Mild: 5-9 Moderate: 10-14(Support) Moderately Sever: 15-19 (Antidepressant or Psychotherapy) Severe: 20 + (Antidepressant + Psychotherapy

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Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES 8D)

Patient Name:_____ Date: _____/_____/2017

INSTRUCTIONS: Please read the following statements carefully. Each one describes a way that you might (or might not) feel about your drug use. For each statement, circle one number from 1 to 5, to indicate how much you agree or disagree with it right now. Please circle one and only one number for every statement.

	No Strongly Disagree	No, I Disa-gree	Undecided or Unsure	Yes Agree	Yes, I Strongly agree
1. I really want to make changes in my use of drugs.	1	2	3	4	5
3. If I don't change my drug use soon, my problems are going to get worse.	1	2	3	4	5
7. I have a drug problem.	1	2	3	4	5
10. I have serious problems with drugs.	1	2	3	4	5
12. My drug use is causing a lot of harm.	1	2	3	4	5
15. I know that I have a drug problem.	1	2	3	4	5
17. I am a drug addict.	1	2	3	4	5
Total the above Columns (1+3+7+10+12+15+17)*Recognition*					
2. Sometimes I wonder if I am an addict.	1	2	3	4	5
6. Sometimes I wonder if my drug use is hurting other people.	1	2	3	4	5
11. Sometimes I wonder if I am in control of my drug use.	1	2	3	4	5
16. There are times when I wonder if I use drugs too much.	1	2	3	4	5
Total the above Columns (2+6+11+16) *Ambivalence*					
4. I have already started making some changes in my use of drugs.	1	2	3	4	5
5. I was using drugs too much at one time, but I've managed to change	1	2	3	4	5
8. I'm not just thinking about changing my drug use, I'm already doing something about it.	1	2	3	4	5
9. I have already changed my drug use, and I am looking for ways to keep from slipping back to my old pattern	1	2	3	4	5
13. I am actively doing things now to cut down or stop my use of drugs	1	2	3	4	5
14. I want help to keep from going back to the drug problems that I had before	1	2	3	4	5
18. I am working hard to change my drug use	1	2	3	4	5
19. I have made some changes in my drug use, and I want some help to keep from going back to the way I used before.	1	2	3	4	5
Total the above columns (4+5+8+9+13+14+14+18+19)*Taking Steps*					

Recognition: _____**Ambivalence**: _____**Taking Steps**: __ _____

High Scores above 30: Recognition, Desire to change & perceive harm if they do not change.
High Scores above 15: Ambivalence or uncertainty with openness to reflection
High Scores above 30: Taking Steps, change is underway & may want help to prevent backsliding. Real high score predictive of successful change

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URICA: University of Rhode Island Change Assessment (Stage of Change)

Please indicate the extent to which you tend to agree or disagree with each statement. In each case, make your choice in terms of how you feel right now, not what you have felt in the past or would like to feel. For all the statements, answer in terms of what you write on the "Habit / Study Problem" line below. There are FIVE possible responses to each of the items in the questionnaire:

Habit/Study Problem: **1 = Strongly Disagree 2 = Disagree 3 = Undecided 4 = Agree 5 = Strongly Agree**

Patient Name:_____ Date: _____/_____/2017

Habit / Study / Problem	Place the Number 1-5 You agree				
1. As far as I'm concerned, I don't have any habits that need changing.	1	2	3	4	5
5. I don't have a problem with organizing my time or studying. It doesn't make much sense for me to be here.	1	2	3	4	5
11. Being here is pretty much a waste of time for me because the problem doesn't have to do with me.	1	2	3	4	5
13. I guess I have faults, but there's nothing that I really need to change.	1	2	3	4	5
23. I may be part of the problem, but I don't really think I am.	1	2	3	4	5
26. All this talk about learning styles and how to study in medical school is boring.	1	2	3	4	5
29. I have worries/bad habits but so does the next guy. Why spend time thinking about them?	1	2	3	4	5
31. I would rather keep doing what I am doing than try to change them.	1	2	3	4	5
Total Each column(1+5+11+13+23+26+29+31+) (Add) *Pre-contemplation(PC)*					
2. I think I might be ready for some self-improvement.	1	2	3	4	5
4. It might be worthwhile to work on my problem.	1	2	3	4	5
8. I've been thinking that I might want to change something about myself.	1	2	3	4	5
12. I'm hoping talking about changing my study skills will help me to better understand myself.	1	2	3	4	5
15. I have a problem and I really think I should work at it.	1	2	3	4	5
19. I wish I had more ideas on how to solve the problem.	1	2	3	4	5
21. Seeing a learning specialist may be a help to me.	1	2	3	4	5
24. I hope that someone here will have some good advice for me.	1	2	3	4	5
Total of (2+4+8+12+15+19+21+21+24)Add in each column *Contemplation(C)*					
3. I am doing something about the problems/habits that had been bothering me.	1	2	3	4	5
7. I am finally doing some work on my problem.	1	2	3	4	5
10. At times my problem is difficult, but I'm working on it.	1	2	3	4	5
14. I am really working hard to change.	1	2	3	4	5
17. Even though I'm not always successful in changing, I am at least working on my problem.	1	2	3	4	5
20. I have started working on my problems but I would like help	1	2	3	4	5
25. Anyone can talk about changing; I'm actually doing something about it.	1	2	3	4	5
30. I am actively working on my problem.	1	2	3	4	5
Total of (3+7+10+14+20+25+30) Add in Each column Action / Participation(Ac)					
6. It worries me that I might slip back on a problem I have already changed, so I am here to seek help.	1	2	3	4	5
9. I have been successful in working on changing but I'm not sure I can keep up the effort on my own	1	2	3	4	5
16. I'm not following through with what I had already changed as well as I had hoped, and I'm here to change	1	2	3	4	5
18. I thought once I had resolved my problem I would be free of it, but sometimes I still find myself struggling with it.	1	2	3	4	5
22. I may need a boost right now to help me maintain the changes I've already made	1	2	3	4	5
27. I'm here to prevent myself from having a relapse of my problem.	1	2	3	4	5
28. It is frustrating, but I feel I might be having a recurrence of a problem I thought I had resolved.	1	2	3	4	5
32. After all I had done to try to change my problem, every now and again it comes back to haunt me.	1	2	3	4	5
Total of (6+9+16+18+22+27+28+32) Add in Each Column ***Maintenance Item(M)***					

Divide total score of each group by 7 gives the average for each Group. Readiness for change= (Ave C + Ave A + Ave M) - Ave PC

Compare the Readiness for change score to the following group means. Chose the stage whose group average is closest to the computed Readiness score.

Group Average for each Group: Pre-contemplation 9.3 Contemplation 11.0 Action or Participation 12.6 Maintenance Not Available

SBQ-R Suicide Behaviors Questionnaire-Revised

Instructions: Please check the number beside the statement or phrase that best applies to you

1. **Have you ever thought about or attempted to kill yourself ? Check one only**
   - □ **1. Never**
   - □ **2. It was just a brief passing thought**
   - □ **3a. I have had a plan at least once to kill myself but did not try to do it**
   - □ **3b. I have had a plan at least once to kill myself and really wanted to die.**
   - □ **4a. I have attempted to kill myself, but did not want to die**
   - □ **4b. I have attempted to kill myself, and really hoped to die**

2. **How often have you thought about killing yourself in the past year?**
   - □ **1. Never**
   - □ **2. Rarely (1 time)**
   - □ **3. Sometimes (2times)**
   - □ **4. Often (3-4times)**
   - □ **5. Very often (5 05 more times)**

3. **Have you ever told someone that you were going to commit suicide, or that you might do it?**

   - □ **1. No**
   - □ **2a. Yes, at one time, but did not really want to die**
   - □ **2b. Yes, at one time, and really wanted to die**
   - □ **3a. Yes, more than once, but did not want to do it**
   - □ **3b. Yes, more often than once, and really wanted to do it**

4. **How likely is it that you will attempt suicide someday?**
   - □ **0. Never**
   - □ **1. No chance at all**
   - □ **2. Rather unlikely**
   - □ **3. Unlikely**
   - □ **4. Likely**
   - □ **5. Rather likely**
   - □ **6. Very likely**

Total Score: _____ Score of 7 or More _____