

**Bradford Medical Centre**

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**Methadone/Suboxone Registration Form**

Please complete the following questionnaire as accurately and honestly as possible so we can determine what kind of treatment would serve you the best.

Patient Last name: .....

First name: .....

Name of family doctor: .....

How did you hear from us? .....

**Drug History:**

Drug	Amount used	How long daily user	Route taken	First used	Last used
Heroin					
Other narcotics					
Cocaine					
Benzodiazepines (valium, Ativan)					
Barbiturates(fiorinal)					
Amphetamines					
Cannabis(pot, hash)					
Cigarettes (packs per day)					
Alcohol					



- Any children? Yes No - whose custody are the children in? .....
- Do they abuse alcohol/drugs? Yes No
- Are people close to you aware of your drug problem? Yes No
- Are they supportive for your decision to join the program? Yes No

**Legal status:**

- Are you currently on probation or parole? Yes No  
If yes until when? .....
- Is treatment a condition of your probation? Yes No  
If yes, when?.....
- Do you have any court dates pending? Yes No  
If yes, when?.....
- Do you have previous convictions? Yes No  
If yes for what? .....
- Have you been incarcerated? Yes No  
If yes for what? .....
- Have you been in jail? Yes No  
If yes for how long in total? .....
- Have you been charged with impaired driving? Yes No
- Have you been charged with a crime that included a weapon or violence? Yes No

**About your addiction: In the last 12 month**

- Do you need more and more of the drug you are using to get the same effect? Yes No
- What symptoms do you experience if you suddenly stop taking the drug?  
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- Do you frequently take more drugs than you planned or use it for longer than you planned to? Yes No
- Have you had many unsuccessful attempts to cut down on your drug use? Yes No
- Do you spend a lot of your day getting, using and recovering from the effects of your drugs? Yes No

- Have you given up work, social or other things you used to do because of your drug use? Yes No
- Do you keep taking drugs despite the harm and problems it is causing you? Yes No

Do you drive a car? Yes No

Why have you come for treatment at this time?  
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What type of treatment you feel that you need?  
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What are your goals for treatment?  
.....

**I confirm that information above is accurate to the best of my knowledge.**

Patient Signature: .....

Date: .....