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Your 1st Visit

Your first visit is generally the longest, and may last anywhere from 1 to 2 hours.

CHECKLIST FOR 1st VISIT:
- Be able to provide a urine sample, no medication will be provided without giving a urine sample.
- If you are planning to start Suboxone you will need to arrive experiencing moderate **opioid withdrawal** symptoms.
- Bring completed **forms** and arrive 30 minutes early.
- Bring **ALL medication bottles.**
- **Fees due** at time of visit (cash, check, or credit card).
- Bring a copy of your insurance card, a picture ID, and credit card.
- When you arrive you will be asked to complete a financial form, general health form, and HIPPA form.

INITIAL SUBOXONE VISIT

When preparing for your first office visit for Suboxone there are a couple of logistical issues you may want to consider.
- You may not want to return to work after your visit-this is very normal, so just plan accordingly.
- Because SUBOXONE can cause drowsiness and slow reaction times, particularly during the first few weeks of treatment, driving yourself home after the first visit is generally not recommended, so you should make arrangements for a ride home.

It is very important to arrive for your first visit already experiencing mild to moderate opioid withdrawal symptoms. If you are in withdrawal, buprenorphine will help lessen the symptoms. However, if you are not in withdrawal, buprenorphine will "override" the opioids already in your system, which will cause severe withdrawal symptoms.

The following guidelines are provided to **ensure that you are in withdrawal for the visit**. (If this concerns you, it may help to schedule your first visit in the morning: some patients find it easiest to skip what would normally be their first dose of the day.)

- No methadone or long-acting painkillers for at least 24 – 46 hours
- No heroin or short-acting painkillers for at least 12 – 24 hours

Bring ALL medication bottles with you to your first appointment.

Before you can be seen by the doctor, all of your paperwork must be completed, so bring all your completed forms with you or arrive about 30 minutes early. In addition, you will need to pay the doctor's fees prior to treatment.

Urine drug screening is a regular feature of SUBOXONE therapy, because it provides physicians with important insights into your health and your treatment. Your first visit will include urine drug screening, and blood work. If you haven't had a recent physical exam, your doctor may require one either now or soon afterwards. To help ensure that SUBOXONE is the best treatment option for you, the doctor will perform a substance dependence assessment and mental status evaluation. In addition, you and your physician will discuss SUBOXONE treatment, what it involves, and what your expectations of treatment are.

After this initial intake, your doctor will give you a dose of SUBOXONE. Your response to the medication will be evaluated after 1 hour and possibly again after 2 hours. Once the doctor is comfortable with your response, you will be allowed to go home. The doctor will schedule your next visit and give you directions for taking your medication at home. In addition, you will receive instructions on how to contact your doctor in case of emergency, as well as information about your treatment.

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Pain Management Patient Questionnaire

Name: ____

Today's Date:__________________ Date of Birth:_____________

We are interested in understanding more about your pain. Please help us by filling out this questionnaire.

Primary Care Physician

Name: __________________________

Address:_________________________

____

Phone:__________________________

Referring Physician (if different)

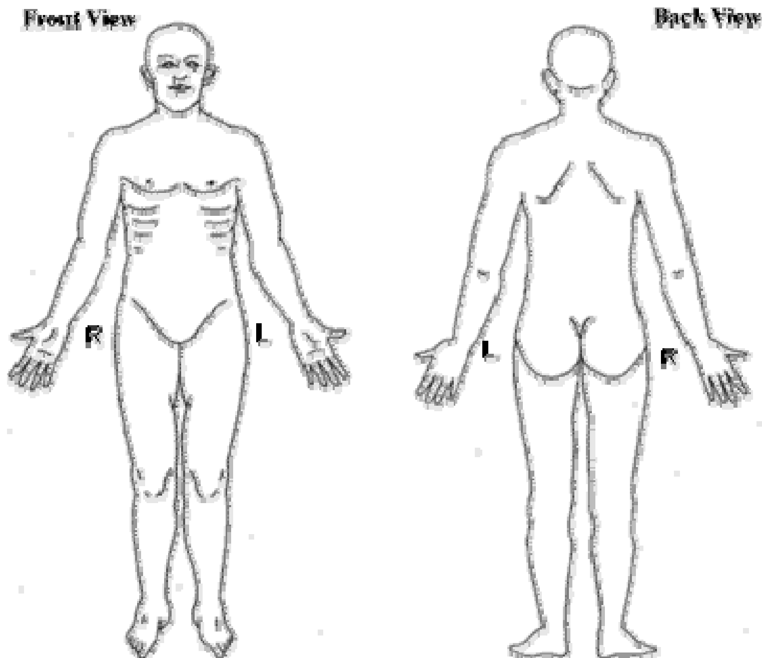
Name:___________________________

Address:_________________________

____

Phone:__________________________

1. Where is the location of your pain? ____
   Please use the diagram below to indicate where your most painful areas are located. Shade in these areas darkly and shade your less painful areas lightly.



2. When did your pain problem begin, or if your pain is related to a specific injury, what date did the injury occur? Month:__________ Day :________Year:__________

3. How did your pain first start? (Car accident? Fall? Job related injury? Etc.)
____

____

____

4. Please circle the level of your pain for the following?
Average daily level of pain:
0 (0 is no pain) 1 2 3 4 5 6 7 8 9 10 (10 is the worst pain imaginable)

Using the same scale, what level of pain is ACCEPTABLE for you?
0 (0 is no pain) 1 2 3 4 5 6 7 8 9 10 (10 is the worst pain imaginable)

5. How often do you have pain? Please circle one. **Constant Intermittent (Occasionally)**

6. Circle the words below which best describe your pain and related symptoms:

Dull Sharp Shooting Stabbing Burning Electric Arching

Numbness Tingling Weakness Coldness Spasms or Tightness

7. Are three things that influence your pain? Please check all that apply.

Treatment	Worsens	Relieves	No Difference	Comments
Exercise				
Walking				
Massage				
Sitting				
Standing				
Temperature (hot)				
Temperature (cold)				
Emotional Stress				
Sexual Activity				
Medicines				
Stairs				
Other				

8. What medications for pain have you tried in the past?
____
____
____

9. What treatments have you had in the past for your pain? Please check all that apply.

TREATMENT	HELPFUL	NOT HELPFUL	COMMENTS
Surgery			
Nerve blocks			
Steroid injection			
Acupuncture			
Trigger point injection			
TENS unit			
Heat/ice treatment			
Biofeedback			
Hypnosis			
Relaxation training			
Counseling			
Physical therapy			
Other			

10. Please circle any of the following medical conditions you now have or have had in the past:

Diabetes **Arthritis** **Cancer** **Ulcer** **Heart Problems** **Bleeding Problems**

Kidney Problems **Respiratory Problems (COPD/Asthma)** **Seizures**

Infectious Disease **Neurogenic** **Disease** **High Blood Pressure**

11. Have you ever been seen by another pain specialist? **Yes** **No**

If so, what is the name of the doctor or practice?____

12. Are you currently working? **Yes** **No** **Retired**

13. Are you being treated under Worker's Compensation? **Yes** **No**

14. Are you currently receiving or applying for disability benefits? **Yes** **No**

15. Are you involved in any legal action related to your pain problem or considering it in the future?

16. Circle any of the following tests you have had in the past 24 months:

X-ray **CT scan** **MRI** **EMG**

17. Please list all past surgeries/hospitalizations:

DATE	SURGERY OR REASON FOR HOSPITALIZATION

18. Please list all your **current** medications, including “over the counter medications” below: If more room is needed, use the back side of this paper.

Medicine	Strength (milligrams?)	Total daily dose	Is it effective?	Who ordered it?

19. Please list all your **ALLERGIES:**____

____

20. Do you have a history of or experience any of the following symptoms or problems?
Please circle **Yes** or **No** for each problem.

Yes	**No**	Blurry vision
Yes	**No**	Glaucoma
Yes	**No**	Ringing in your ears
Yes	**No**	Clenching your teeth
Yes	**No**	Tightness in your chest or chest pain
Yes	**No**	Heart disease or irregular heart beats
Yes	**No**	Need to sleep sitting up in order to get your breath
Yes	**No**	Difficulty breathing
Yes	**No**	Emphysema
Yes	**No**	Asthma
Yes	**No**	Abdominal pain
Yes	**No**	Stomach ulcers or gastritis
Yes	**No**	Irregular bowels
Yes	**No**	Irritable bowel disease
Yes	**No**	Blood in you stools
Yes	**No**	Pelvic pain
Yes	**No**	Frequent urination
Yes	**No**	Inability to urinate
Yes	**No**	Seizures
Yes	**No**	Frequent headaches
Yes	**No**	Episodes of blacking out or passing out
Yes	**No**	Unexplained fevers
Yes	**No**	Excessive fatigue
Yes	**No**	Difficulty falling or staying asleep
Yes	**No**	Rashes
Yes	**No**	Rheumatoid arthritis, lupus, sarcoid or scleroderma
Yes	**No**	Diabetes
Yes	**No**	Thyroid problems
Yes	**No**	Depression
Yes	**No**	Anxiety

Physician Only
I have reviewed this list with the patient____

______________________________________ ____________________________
Physician Signature Date