



Periodic/Quarterly Assessment Opioid Treatment

► Date Collected:

► ESM Client ID:

Provider ID:

All Questions marked with a ► must be completed

Boxes marked with ★ = Refer to key at end of form

First Name:

Middle Initial:

Last Name:

Suffix:

► 1. Current Employment status:

Work full time

Unemployed, seeking work

Unable to work

Work part time

Unemployed, not seeking work

Other

► 2. Number of arrests in the past 3 months (0-93):

► 3. During the past 3 months, have there been services you think you have needed but have not been provided to you by the program or by a referral from the program?*

1 None

2 A Few

3 Some

4 A Lot

► 4. During the past 3 months, do you feel you have been treated fairly by the program staff?

1 Not at all

2 Sometimes

3 Most of the Time

4 Always

► 5. Frequency of drug use in the past 3 months (enter one code for a-f)

Frequency of Last Use Codes: 1 = No use 2 = Less than once per month 3 = 1-3 times per month 4 = 1-2 times per week 5 = 3-6 times per week 6 = Daily

a. Cocaine or crack

c. Other narcotics or opiates

e. Alcohol

b. Heroin

d. Marijuana

f. Injected drug use

► 6. In general, how would you describe your current health?

1 Excellent

2 Very Good

3 Good

4 Fair

5 Poor

► 7. During the past 3 months, how much difficulty did you have doing your daily activities, both inside and outside the home, due to physical or emotional problems?

1 None

2 A little bit

3 Some

4 Quite a bit

5 Unable to do daily activities

► 8. During the past 3 months, how many nights were you hospitalized for physical problems? (0-92):

► 9. During the past 3 months, how many nights were you in a detox facility? (0-92):

► 10. During the past 3 months, how many visits to an emergency room and/or urgent care facility did you make? (0-100):

► 11. During the past 3 months, how much were you distressed (bothered) by:

1-- Not at all

2 -- A little/slightly

3 -- Moderately

4 -- A lot/extremely

a. Nervousness or shakiness inside?

b. Suddenly being scared for no reason?

c. Feeling fearful?

d. Spells of terror or panic?

e. Feeling that something bad is going to happen?

▶ 12. In the past 3 months, how much were you distressed (bothered) by:	1 -- Not at all	2 -- A little/slightly	3 -- Moderately	4 --A lot/extremely
a. Blaming yourself for things?				
b. Feeling blue?				
c. Worrying too much about things?				
d. Feeling no interest in things?				
e. Feeling hopeless about the future?				
f. Feeling worthless?				
g. Feeling guilty for things that may not be your fault?				

▶ 13. In the past 3 months, did you think about suicide?	1 <input type="checkbox"/> Yes	2 <input type="checkbox"/> No
▶ 14. In the past 3 months, did you attempt suicide?	1 <input type="checkbox"/> Yes	2 <input type="checkbox"/> No
▶ 15. In the past 3 months, how supportive would you say the people closest to you are of your seeking substance abuse treatment at this time?		
1 <input type="checkbox"/> Not supportive or opposed	2 <input type="checkbox"/> Not very supportive	3 <input type="checkbox"/> Somewhat supportive
4 <input type="checkbox"/> Very supportive		
▶ 16. In the past 3 months, would you say that none of the people, a few of the people, or most of the people you are close to are currently abusing drugs?		
1 <input type="checkbox"/> None	2 <input type="checkbox"/> One or a few	3 <input type="checkbox"/> Most

RECORD DATA

▶ 17. Does client have a current prescription opiate(s)?	1 <input type="checkbox"/> Yes	2 <input type="checkbox"/> No
▶ 18. Does the client have a current prescription for Benzodiazepine(s)?	1 <input type="checkbox"/> Yes	2 <input type="checkbox"/> No
▶ 19. Urinalysis Results Received Over the Past 3 Months. EXCLUDE the client's initial urine screen		
Drug	# of Urine Screens for Drug	# of Testing Positive for Drug
Cocaine		
Opiates		
Methadone		
Benzodiazepines		
Other Drugs		

▶ 20. Which medication-assisted treatment is the client currently using?	<input type="checkbox"/> Methadone	<input type="checkbox"/> Buprenorphine	<input type="checkbox"/> Injectable Naltrexone
<i>If client is currently using injectable naltrexone, skip Qs. 21 and 22 and go to Q. 23</i>			
▶ 21. Has the client received a dose in the past 2 weeks?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
▶ 22. What was the client's last dose? (mg):			
▶ 23. In what phase of treatment was the client?			
<input type="checkbox"/> Active treatment	<input type="checkbox"/> Stabilization treatment	<input type="checkbox"/> Medically supervised withdrawal	<input type="checkbox"/> Medical maintenance