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