Suboxone/buprenorphine Therapy Progress Report

Patient Name:____ **Suboxone dose**________**mg/day** **Date:**__________________

Please tell us how you are doing by answering the following questions:

Are you having frequent cravings for opioids?	YES	NO
Are you having problems with pain?	YES	NO
Are you having constipation?	YES	NO
Are you having trouble sleeping?	YES	NO
Are you still smoking?	YES	NO
Do you feel depressed most days?	YES	NO
Do you have frequent headaches?	YES	NO
Do you feel anxious most of the time?	YES	NO
Have you used any alcohol or drugs since your last visit?	YES	NO

*If YES please describe what you used, when, and how much:____

____

Please describe any major life changes, triggers, or stressors that have occurred since your last visit:

____

____

____

Are you currently working? YES NO
*If YES where: ____

Are you currently in school or training? NO YES *If yes where:____

Do you attend any of the following:

Individual or group Counseling?	NO	YES	*If yes where:____
Alcoholics Anonymous?	NO	YES	*If yes where:____
Narcotics Anonymous?	NO	YES	*If yes where:____
Celebrate Recovery?	NO	YES	*If yes where:____
Church or Other group?	NO	YES	*If yes where:____

Do you feel that you need a change in your Suboxone/buprenorphine dose? NO YES Down Up

Physician Comments: ____