

## SUBJECTIVE ASSESSMENT OF OPIOID ADDICTION OR WITHDRAWAL

Please score each question according to how you have felt or behaved in the **last 30 days**.

Answer each question as honestly as possible.

1	<b>Withdrawal symptoms:</b> I feel anxious, restless, shaky or twitch	0	1	2	3	4
2	I have excessive yawning	0	1	2	3	4
3	I sweat, have hot or cold flashes or goosebumps	0	1	2	3	4
4	My bones and muscles ache all over if I miss a dose	0	1	2	3	4
5	I feel nauseous, vomit or have stomach cramps	0	1	2	3	4
6	<b>Red Flags:</b> I have trouble concentrating, completing tasks or have memory problems	0	1	2	3	4
7	I have trouble controlling my anger, get in arguments, think about hurting myself or others	0	1	2	3	4
8	I or someone I know has worried about how I am handling my medications	0	1	2	3	4
9	I have had to take more of my medication than prescribed	0	1	2	3	4
10	I have borrowed pain medication from someone else, been to ER or gotten it from another doctor	0	1	2	3	4
11	I have used pain medication for symptoms other than pain (sleep, relieve stress, improve mood)	0	1	2	3	4

\_\_\_ Completed via Teleconference

PRINT NAME \_\_\_\_\_ DOB \_\_\_\_\_ SIGN \_\_\_\_\_ DATE \_\_\_\_\_