Time for Change (Sample Form)

The questions below will be used to help with your care. If you have an issue with filling this out ahead of time a paper copy can be given to you in the office. You will be given a code to use instead of your name - please do not put your name on the questionnaire.
* Required

Code _____

Gender	
Female	Trans
Male	Non-binary
LGBQ	

Did you finish High school? *
Yes
No

In the past 3 months have you used the following? Check all that apply:					
	Swallow	Snort	Smoke	Inject	Inhale
Alcohol					
Heroin					
Methadone					
Morphine/ Dilaudid/ Hydroporphone/Oxycontin etc					
Fentanyl					
Cocaine					
Benzos					
Cannabis					
Stimulants (ritalin/ amphetamines)					
Club drugs (MDMA etc)					
Inhalants					
Hallucinogens					

For the entire last year, have you ___? Tick the box if this applies to you.	**X**
Taken your drug in larger amounts than intended or for longer than intended?	
Tried repeatedly and unsuccessfully to cut down or control your use of the drug?	
Spent a significant amount of your day trying to find or use or recover from your drug?	
Experienced "craving" or a strong desire or urge to use?	

Failed to fulfill a major role or obligation in your life a a result of your drug use?	
Continued to use despite persistent interpersonal and/or social problems?	
Given up the things you loved to do because of your drug use?	
Put yourself repeatedly in harms way on account of your drug use?	
Continued to use despite knowing you had a problem	
Had to increase the dose to get the same effect?	
Experienced withdrawal from the drug when not using?	
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Given up the things you loved to do because of your drug use?	
Put yourself repeatedly in harms way on account of your drug use?	
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Had to increase the dose to get the same effect?	
Experienced withdrawal from the drug when not using?	

What is your drug of choice?

On an average day how much would you use

Do you take any prescribed medications: please list them

Do you have any allergies? If yes - please list

Have you been on Methadone in the past *
Yes
NO

Have you been in detox? *
Never
1-3 times
more than 3 times

Have you ever been to treatment? (Humberwood the Grace Centre etc..) *
Never
Once
More than once

Have you ever had the following problems as a result of your drug use?	Yes
Medical Problems	
Legal Problems	
Broken Relationships	
Lost jobs	
Financial problems	
Homelessness	
Medical Problems	
Legal Problems	
Broken Relationships	
Lost jobs	
Financial problems	
Homelessness	

Have you ever been formally diagnosed with the following	Yes
Eating Disorder	
Chronic Pain	
PTSD	
Personality disorder	
Suicide attempts	
Depression	
Anxiety	
Bipolar illness	
ADHD	
Schizophrenia	
Social Anxiety disorder	
OCD	
Any psychotic episode	
None of the above	

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Chronic Pain	
PTSD	

Personality disorder	
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Depression	
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ADHD	
Schizophrenia	
Social Anxiety disorder	
OCD	
Any psychotic episode	
None of the above	

Have you ever suffered an accidental overdose and had to be resuscitated with naloxone? *
Yes
NO

Are you Hepatitis C Positive ? *
Yes
No
Don't know

Have you been tested for Hep C/HIV in the past 3-6 months? *
Yes
No

Are you currently living (check which one applies)
Tick the one that applies
With Parents
With Partner/Spouse
With Friends
With strangers (boarding house)
Alone
With Parents
With Partner/Spouse
With Friends
With strangers (boarding house)
Alone

Do you have someone who is a support for your recovery? *
Yes
No

Have you suffered significant trauma (mental, physical, sexual) in your life thus far? *
Yes

No

What do you want for your life from today on?

Are you willing to engage in counselling and 12 step meetings as part of your recovery? *
Yes
No

Do you have hope that you can change? *
Yes
No