

Initial Assessment Form for Methadone Treatment

Assessment date:/_/ Place	ee:	Assessed by		
1. PERSONAL DETAILS				
Surname For	rename(s)	Initials _		
Relationship/Marital Status	Gender			
D.O.B	Age			
Address				
Telephone No				
Can we write to you at the above address:	Yes 🗖 No 🗖	Can we call you on this Mobile:	Yes 🗖	No 🗆
Call we call in person to the above address:	Yes 🗆 No 🗆	Can we call you on this Landline	: Yes 🗖	No 🗖
Nationality		v		
G.P Name and Address:				
Medical Card: Yes ☐ No ☐ Medical Ca	ard Number			
HSE Area: PPSN/PRSI N	No			
Contact Type with this clinic (New / Old Cli	ient)			
2. CURRENT LIVING ARRANGEMENT	NTS			
Accommodation type:				
family home \square rented \square Own home	homeless 🗖 I	nstitution (prison, clinic)		
Who do you live with? alone \Box with	partner 🗖 Hu	sband/wife with parents		
Living with drug users: Yes No No S	pecify:			
No. of children: Ages	Child Care iss	sues:		
Social workers involved: Yes 🗖 No 🗖 If	Yes please Specify	:		

3. EDUCATION A Age left school						ucational level		
Occupation								
_								
If working, what da	iys ao	you v	vork:			what nours do	you work?	
4. FAMILY HIST	ORY	<u> </u>						
Next of kin:			Ad	dress			Phone	
Family aware of Dr	Family aware of Drug Use? Yes ☐ No			No 🗆	How many brothers and sisters?:			
History of Substance	e use	in fan	nily?: Yes	No 🗆				
						Family Me	mbers affected	:
Alcohol:	Yes		No 🗆	Ple	ease spe	cify:		•
Drugs	Yes		No 🗆		-	cify:		
Both	Yes		No 🗖	Ple	ease spe	cify:		
Age first used drug First drug taken	S							
Drugs used		F	Route	Frequen	icy	Quantity	Duration	Age 1st used
Alcohol								
Cannabis								
Hallucinogens Benzodiazepines								
(Hypnotics &								
Sedatives)								
Heroin (Opiates)								
Methadone (Opiate								
Cocaine (Stimulant	s)							
Amphetamine (Stimulants)								
Ecstasy (Stimulants	s)							
Other								
Ever injected:			Yes 🛚	No 🗆	Age fi	rst injected:		
				D				
Injected in last mon	ith?	`	Yes 🗖	No 🗖				
Injected in last mon If using I.V. needles								

PREVIOUS TREATMENT No□ Which drug?_____ **Ever treated for drug use before?** Yes 🗖 Previous treatment history_____ Reason for leaving ___ _____ from_____ to____ **Longest time Drug Free** How Supports habit **IF OPIATE HABIT:** How long injecting opiates How long smoking opiates **Current methadone treatment** Yes \square ☐ Details: _____ No Dosage _____ **Previous maintenance** Yes \square No **6. MEDICAL HISTORY** General appearance / Behaviour **Medical History Present Medical Status: Prescribed medications: Tobacco Use:** Ever seen by a Psychiatrist/Psychologist? Yes No Current links with other agencies/therapist Yes No **Details of agency:** History of Overdoses: Yes □ No □ Date(s)_____ History of Self Harm Yes □ No □ **Details:**_____

7.VIROLOGY

Are you aware or	f your viral status	? Have you ever had an::			
HIV test	Yes □ No □	If YES was it:	(1-Positive	2-Negative	3-Unknown)
Hepatitis B test	Yes 🗆 No 🗅	If YES was it:	(1-Positive	2-Negative	3-Unknown)
Hepatitis C test	Yes □ No □	If YES was it:	(1-Positive	2-Negative	3-Unknown)
Unprotected Inte	ercourse Yes	□ No □			
Any STIS ever	Yes	□ No □ Details:			
8. FORENSIC	<u>HISTORY</u>				
Ever in prison?	Yes 🗆	No 🗆			
Currently on pro	obation? Yes	No 🗆			
Any current char	rges pending?:	Yes			specify
Details of previous	us criminal charge	es			