Controlled Substance Checklist

Name____________________________________Date___________

In order to increase your opportunity for successful treatment, we have found this checklist to be a useful and important tool.

Please be honest and forthright when completing this form, understand that the information may be validated through drug testing. Incomplete reporting to your provider may result in you being discharged from the practice or having your Suboxone dose reduced.

Please indicate any and all substances that you have or have not used since your last visit.
NEW PATIENTS- indicate any and all substances used or not used in the last 30 days.
YES -I have used since my last visit, NO-I have not used since my last visit.

OPIATES

Suboxone/buprenorphine	YES	NO	hydrocodone	YES	NO
OxyContin/oxycodone	YES	NO	Avinza/morphine	YES	NO
Codeine	YES	NO	Duragesic/fentenyl	YES	NO
Dilaudid/hydromorphone	YES	NO	Demerol/meperidine	YES	NO
methadone	YES	NO	Heroin	YES	NO

Others ______________________ __________________________

SEDATIVES

Xanax/alprazolam	YES	NO	Ativan/lorazepam	YES	NO
Klonopin/clonazepam	YES	NO	Valium/diazepam	YES	NO
phenobarbital	YES	NO	Ambien/zolpidem	YES	NO
Lunesta/eszopiclone.	YES	NO	Sonata/zaleplon	YES	NO
Alcohol	YES	NO	GHB	YES	NO
Tranxene/clorazepate	YES	NO			

Others____ YES NO

STIMULANTS

Cocaine	YES	NO	Methamphetamine	YES	NO
Adderall/amphetamine	YES	NO	Ritalin/methylphenidate	YES	NO
Vyvanse/amphetamine	YES	NO	Concerta	YES	NO
Provigil/modafinil	YES	NO	Nuvigil/armodafinil	YES	NO
Others				YES	NO

CANNABIS/HALLUCINOGENS

Marijuana	YES	NO	Hashish	YES	NO
LSD	YES	NO	Mushrooms	YES	NO
PCP	Yes	NO	Ecstasy/MDMA	YES	NO

Signature

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