

OPIOID RELAPSE FORM

Name _____ Date ____/____/____ Time: ____:____ AM / PM

CIRCLE ONLY ONE NUMBER which best corresponds to your symptoms and then **ENTER THAT NUMBER ON THE RIGHT.**

SWEATING *During the past 30 minutes*, are you having unusual chills or hot spells that are not accounted for by room temperature or recent activity: **SCORE**

- 0 - no, none.
1 - maybe just slightly.
2 - yes, there is a little moistness on my skin.
3 - yes, there are beads of sweat on my brow or face.
4 - yes, sweat is streaming off my face.

Please call Dr. Mitchell for important instructions BEFORE using this form at: 786 - 262 - 5750

RESTLESSNESS Are you:

- 0 - able to sit still for 20 to 30 minutes comfortably.
1 - having difficulty sitting still, but are able to do so for 10 to 20 minutes at a time.
3 - frequently shifting or moving your legs or arms to get comfortable.
5 - unable to sit still for more than a few seconds without having discomfort.

ANXIETY OR IRRITABILITY I feel:

- 0 - okay without any unusual anxiety or irritability.
1 - mildly more anxious or irritable than is usual for me.
2 - moderately more anxious or irritable than is usual for me.
4 - severely more anxious or irritable than is usual for me, with participation in this assessment being difficult for me.

STOMACH UPSET *During the past 30 minutes*, is your stomach:

- 0 - okay without any discomfort.
1 - having mild to moderate cramps only.
2 - nauseous like you may vomit, or you are having looser than normal bowel movements.
3 - feeling very bad with vomiting or diarrhea just one time only.
5 - feeling extremely bad with multiple episodes of diarrhea or vomiting.

BODY, BONE OR JOINT ACHES I am having:

- 0 - no more pain than I usually do on a typical day.
1 - mildly more pain than I usually do on a typical day, but I can still function normally without severe achiness.
2 - moderately more pain than I usually do on a typical day, and I can move about but only with severe achiness.
4 - severely more pain than I usually do on a typical day, and I can't even sit still without severe achiness.

NOSE AND EYES *During the past 30 minutes*, I have had:

- 0 - no runny nose or tearing eyes - or - I have a cold or allergies.
1 - nasal stuffiness or unusually moist eyes - I DO NOT have a cold or allergies.
2 - a sometimes running nose or tearing eyes - I DO NOT have a cold or allergies.
4 - a constantly running nose or tearing eyes streaming down my cheeks - I DO NOT have a cold or allergies.

YAWNING *During the past 30 minutes*, I have:

- 0 - not yawned at all.
1 - yawned once or twice.
2 - yawned three or more times.
4 - yawned constantly (every minute or so).

TREMORS Place both hands in front of you with palms facing down. Do you see:

- 0 - no tremors (shaking).
1 - tremors (shaking) that I can feel, but not see.
2 - a slight tremor (shaking) is visible.
4 - your hands are shaking or twitching constantly.

GOOSE BUMPS Place your hands out in front of you and look at the skin on both sides of your arms. I see:

- 0 - smooth skin without any goose bumps.
3 - a few spots of goose bumps.
5 - lots of goose bumps with the hair on my arms sticking straight up off my skin.

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TOTAL:

[Empty box for total score]

Start Med After ____:____ ON ____/____/____ But NOT before total score is _____ or more.