

Telephone (cell)

Telephone (home)

NEXT

Secondary Contact

Name

Telephone

BACK

NEXT



Have you ever taken opioids more often, in larger amounts or over a longer period of time than intended?

 YES NO[BACK](#)

1/12

[NEXT](#)

Have you wanted to stop or cut down using or control your use of opioids?

 YES NO[BACK](#)

2 / 12

[NEXT](#)

Do you spend a lot of time getting or using opioids, or recovering from its effects?

 YES NO[BACK](#)

3 / 12

[NEXT](#)

Have you had a strong desire or urge to use opioids in between times when you normally use?

 YES NO[BACK](#)

4 / 12

[NEXT](#)

Have you missed or been late to work or school, or had trouble at home because you were intoxicated, high, or recovering from the night before?

[BACK](#)

5 / 12

[NEXT](#)

Have you continued to use opioids even though they cause or worsen problems with family members, friends or people at work?

[BACK](#)

6 / 12

[NEXT](#)

Have you given up or reduced important social, work or recreational activities because of your opioid use?

 YES NO[BACK](#)

7 / 12

[NEXT](#)

Have you used opioids in situations that are physically hazardous, such as driving or working with heavy machinery, or other activities that could result in you or someone else being hurt?

 YES NO[BACK](#)

8 / 12

[NEXT](#)

Have you continued to use opioids even though they caused or worsened problems such as depression, anxiety, or irritability or other physical problems?

 YES NO[BACK](#)

9 / 12

[NEXT](#)

Have you found you needed to use much more opioid to get the same effect than when you first started using?

 YES NO[BACK](#)

10 / 12

[NEXT](#)

When you reduced or stopped using opioids, did you have withdrawal symptoms or feel sick when you cut down or stopped using?

[BACK](#)

11 / 12

[NEXT](#)

Are you in the emergency department for an overdose today?

 YES NO

12 / 12

