

Name: _____

Current dose of buprenorphine: _____

Number of strips/ pills used per day: _____ Number of strips left: _____

Any symptoms? _____

Any other drug use? If so, what? _____

How many support groups have you been to since your last refill? _____

Triggers encountered this week: _____

What I did for my recovery this week: _____

How is your physical health? _____

Currently Working? ☐ Yes ☐ No Need to see the provider individually today? ☐ Yes ☐ No



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