ExecuCare Addiction Recovery Center™ Patient ID # _____

FIRST DAY QUESTIONNAIRE

Please fill out completely, and as accurately as possible. There is no wrong answer, and no answer will have a effect on your treatment.

PATIENT NAME_____ **DATE**_____

DAY # ROTATION DAY 1 STAFFS INITIALS_____

		Please score each of the questions below according to how you feel NOW.				
	Symptom	**Not at All**	**A Little**	**Moderately**	**Quite a bit**	**Extremely**
1	I feel Great.	**0**	**1**	**2**	**3**	**4**
2	I sleep well.	**0**	**1**	**2**	**3**	**4**
3	I have a good appetite.	**0**	**1**	**2**	**3**	**4**
4	My mental clarity is good.	**0**	**1**	**2**	**3**	**4**
5	I have a lot of energy.	**0**	**1**	**2**	**3**	**4**
6	I handle stress well.	**0**	**1**	**2**	**3**	**4**
7	I can focus easily.	**0**	**1**	**2**	**3**	**4**
8	I feel like using now.	**0**	**1**	**2**	**3**	**4**
9	I am depressed.	**0**	**1**	**2**	**3**	**4**
10	I am anxious.	**0**	**1**	**2**	**3**	**4**
11	I am joyful.	**0**	**1**	**2**	**3**	**4**
12	I have a lot of motivation.	**0**	**1**	**2**	**3**	**4**
13	I have a constant sexual desire.	**0**	**1**	**2**	**3**	**4**
14	I am very committed to treatment and will do what is necessary to complete treatment.	**0**	**1**	**2**	**3**	**4**

15) Please list any fears or worries that you have.

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