ExecuCare Addiction Recovery Center™

Patient ID # ________

FINAL 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 # **10** 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	My appetite has improved.	**0**	**1**	**2**	**3**	**4**
4	My mental clarity has improved.	**0**	**1**	**2**	**3**	**4**
5	I have more energy.	**0**	**1**	**2**	**3**	**4**
6	I handle stress better.	**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 more aware of my sense of taste.	**0**	**1**	**2**	**3**	**4**
15	I am more aware of my sense of touch.	**0**	**1**	**2**	**3**	**4**
16	I am more aware of my sense of smell.	**0**	**1**	**2**	**3**	**4**
17	I am more aware of my sense of sight.	**0**	**1**	**2**	**3**	**4**
18	I am more aware of my sense of hearing.	**0**	**1**	**2**	**3**	**4**
19	This treatment was harder than I thought it would be.	**0**	**1**	**2**	**3**	**4**
20	I feel this treatment has changed me physically.	**0**	**1**	**2**	**3**	**4**
21	I feel this treatment has changed me mentally.	**0**	**1**	**2**	**3**	**4**

22.) PLEASE rank on a scale of 1 (being mild) to 10 (being severe) and write down which days, if any, you had the following WITHDRAWL (not due to chronic, or other disorders) symptoms.

Pain (Where) ______________________________
Vomiting______________________________
Seizure______________________________
Dizzy______________________________
Diarrhea______________________________
Heart Fluttering______________________________
Overly Tired______________________________

Nausea______________________________
Sweats______________________________
Headache______________________________
Weak______________________________
Rapid Pulse______________________________
Insomnia______________________________

23.) I am very committed to the recovery process. I understand this means getting regularly scheduled boosters and following up with therapy. (**CIRCLE ONE**) (Strongly Agree) (Agree) (Neutral) (Slightly Disagree) (Disagree) (Strongly Disagree)