

Subjective Opiate Withdrawal Scale (SOWS)

Date: _____ Clinic ID# _____ T _____ P _____ R _____ B/P _____

From the time of your previous dose of methadone, please indicate if you are having any of the following withdrawal symptoms by rating its severity .						How long AFTER your last dose did you begin to feel this symptom?			
	Symptom	Not at all	A Little	Moderate	Quite a bit	Onset (hrs)			
1	Anxious/Nervous	0	1	2	3	<input type="checkbox"/> 3-4	<input type="checkbox"/> 8	<input type="checkbox"/> 16	<input type="checkbox"/> 24
2	Body Aches & Pains	0	1	2	3	<input type="checkbox"/> 3-4	<input type="checkbox"/> 8	<input type="checkbox"/> 16	<input type="checkbox"/> 24
3	Constipation	0	1	2	3	<input type="checkbox"/> 3-4	<input type="checkbox"/> 8	<input type="checkbox"/> 16	<input type="checkbox"/> 24
4	Diarrhea	0	1	2	3	<input type="checkbox"/> 3-4	<input type="checkbox"/> 8	<input type="checkbox"/> 16	<input type="checkbox"/> 24
5	Drug Hunger/Craving	0	1	2	3	<input type="checkbox"/> 3-4	<input type="checkbox"/> 8	<input type="checkbox"/> 16	<input type="checkbox"/> 24
6	Goosebumps	0	1	2	3	<input type="checkbox"/> 3-4	<input type="checkbox"/> 8	<input type="checkbox"/> 16	<input type="checkbox"/> 24
7	Hot/Cold Flashes	0	1	2	3	<input type="checkbox"/> 3-4	<input type="checkbox"/> 8	<input type="checkbox"/> 16	<input type="checkbox"/> 24
8	Muscle Twitching	0	1	2	3	<input type="checkbox"/> 3-4	<input type="checkbox"/> 8	<input type="checkbox"/> 16	<input type="checkbox"/> 24
9	Nausea	0	1	2	3	<input type="checkbox"/> 3-4	<input type="checkbox"/> 8	<input type="checkbox"/> 16	<input type="checkbox"/> 24
10	Restlessness	0	1	2	3	<input type="checkbox"/> 3-4	<input type="checkbox"/> 8	<input type="checkbox"/> 16	<input type="checkbox"/> 24
11	Runny Nose	0	1	2	3	<input type="checkbox"/> 3-4	<input type="checkbox"/> 8	<input type="checkbox"/> 16	<input type="checkbox"/> 24
12	Sedation/Sleepiness	0	1	2	3	<input type="checkbox"/> 3-4	<input type="checkbox"/> 8	<input type="checkbox"/> 16	<input type="checkbox"/> 24
13	Shaking	0	1	2	3	<input type="checkbox"/> 3-4	<input type="checkbox"/> 8	<input type="checkbox"/> 16	<input type="checkbox"/> 24
14	Stomach Cramps	0	1	2	3	<input type="checkbox"/> 3-4	<input type="checkbox"/> 8	<input type="checkbox"/> 16	<input type="checkbox"/> 24
15	Sweating	0	1	2	3	<input type="checkbox"/> 3-4	<input type="checkbox"/> 8	<input type="checkbox"/> 16	<input type="checkbox"/> 24
16	Teary Eyes	0	1	2	3	<input type="checkbox"/> 3-4	<input type="checkbox"/> 8	<input type="checkbox"/> 16	<input type="checkbox"/> 24
17	Vomiting	0	1	2	3	<input type="checkbox"/> 3-4	<input type="checkbox"/> 8	<input type="checkbox"/> 16	<input type="checkbox"/> 24
18	Yawning	0	1	2	3	<input type="checkbox"/> 3-4	<input type="checkbox"/> 8	<input type="checkbox"/> 16	<input type="checkbox"/> 24
Total									

Patient Name (Print) _____ Signature _____ Date: _____
 Patient's Current Dose _____ mg Dose Adjustment Made _____ New Dose _____ mg Effective Date _____
 Nurse Signature _____ Date: _____