Mathers Clinic SOWS: Subjective Opiate Withdrawal Scale

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**	**Extremely**	**Onset (Hrs.)**			
1	**Anxious/Nervous**	0	1	2	3	4	❍ 3-4	❍ 8	❍ 16	❍ 24
2	**Body Aches & Pains**	0	1	2	3	4	❍ 3-4	❍ 8	❍ 16	❍ 24
3	**Constipation**	0	1	2	3	4	❍ 3-4	❍ 8	❍ 16	❍ 24
4	**Diarrhea**	0	1	2	3	4	❍ 3-4	❍ 8	❍ 16	❍ 24
5	**Drug Hunger/Craving**	0	1	2	3	4	❍ 3-4	❍ 8	❍ 16	❍ 24
6	**Goosebumps**	0	1	2	3	4	❍ 3-4	❍ 8	❍ 16	❍ 24
7	**Hot/Cold Flashes**	0	1	2	3	4	❍ 3-4	❍ 8	❍ 16	❍ 24
8	**Muscle Twitching**	0	1	2	3	4	❍ 3-4	❍ 8	❍ 16	❍ 24
9	**Nausea**	0	1	2	3	4	❍ 3-4	❍ 8	❍ 16	❍ 24
10	**Restlessness**	0	1	2	3	4	❍ 3-4	❍ 8	❍ 16	❍ 24
11	**Runny Nose**	0	1	2	3	4	❍ 3-4	❍ 8	❍ 16	❍ 24
12	**Sedation/Sleepiness**	0	1	2	3	4	❍ 3-4	❍ 8	❍ 16	❍ 24
13	**Shaking**	0	1	2	3	4	❍ 3-4	❍ 8	❍ 16	❍ 24
14	**Stomach Cramps**	0	1	2	3	4	❍ 3-4	❍ 8	❍ 16	❍ 24
15	**Sweating**	0	1	2	3	4	❍ 3-4	❍ 8	❍ 16	❍ 24
16	**Teary Eyes**	0	1	2	3	4	❍ 3-4	❍ 8	❍ 16	❍ 24
17	**Vomiting**	0	1	2	3	4	❍ 3-4	❍ 8	❍ 16	❍ 24
18	**Yawning**	0	1	2	3	4	❍ 3-4	❍ 8	❍ 16	❍ 24
	TOTAL									

Patient Name (Print): ______________________________ Signature: ______________________________ Date: ________________

Patient's Current Dose: _____________mg Dose Adjustment Made: _____________ New Dose: _____________mg Effective Date: ________________

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Nurse's Signature

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Date

Adapted from: Handelsman, L., Cochrane, K.J., Aronson, M.J. et al. (1987) *Two New Rating Scales for Opiate Withdrawal, American Journal of Alcohol Abuse*, 13. 293-308.

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