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: _____

_____
Nurse's Signature

_____
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.

04/18

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