Name: ____**Date:** ___________________________

Opioid Treatment Response Inventory – OTRI-4

The following four questions ask you about symptoms of opioid use. Please indicate your answer by circling the correct response.

In the past week….		
1. Have you had any opioid withdrawal symptoms?	Yes	No
2. Have you had any opioid craving?	Yes	No
3. Have you used any illicit opioids?	Yes	No
4. Have you had any medication side effects?	Yes	No