New Hampshire Professionals Health Program

Initial Interview Questionnaire

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Name: **Date:**

Mailing Address: **D.O.B.:**

HOW did you hear about the NH PHP?

What is your licensed medical profession? **License Status?**

Describe your current work setting?

Home phone: **Cell #:** **Work phone:**

Preferred e-mail address:

Work Physical Address:

Name and contact numbers of the following as applicable:

Treating physician: Phone #:
Psychiatrist:____ Phone #: ___________________________
Therapist/counselor: __________________________________ Phone #: ___________________________
Legal representative: Phone #:

MEDICAL HISTORY

List the medical conditions diagnosed over your lifetime regardless of whether you are treating them now:

List all of your surgical procedures and hospitalizations with dates.

Check and write detail if you have ever been evaluated for:

( ) Substance Abuse	( ) Learning Disabilities	( ) ADHD or ADD
( ) Ulcers	( ) GI Bleeding	( ) Sleep apnea
( ) Unexplained Weight Loss/Gain	( ) Inflammatory or Irritable Bowel Disease	
( ) Insomnia / Problems sleeping	( ) Decreased Hearing	( ) Seizures
( ) Depression/Emotional Disorder/Anxiety	( ) Suicide attempts or thoughts	( ) Headaches
( ) Syncope	( ) Metabolic syndrome	( ) Tuberculosis, + PPD
( ) Chronic pain	( ) Back Pain or Sciatica	( ) Diabetes
( ) Chest Pain	( ) Head injury / loss of consciousness / Concussion	
( ) Eating Disorder	( ) Bariatric surgery	

Details:

What is your current health insurer?

List all prescribed, over-the-counter medications, and/or herbal products taken routinely:

Date and provider of most recent dental visit:

Date of your last FULL physical? **Provider:**

SUBSTANCE USE HISTORY

What is your smoking status now and in the past?

Other tobacco use – patches, vaping, spray, lozenges?

What types of alcoholic beverages do/did you drink?

Usual amount: Frequency:
How old were you when you had your first drink?
How old were you when you first got intoxicated?
Have you ever been stopped or charged with a DUI? No / Yes - Dates:
Have you ever: blacked out? Had DTs?
Have you ever taken medicine to help stop or control your drinking?
When was your most recent drink:

Do you often use larger amounts or for a longer time than originally intended? **Yes/no**

Have you had a persistent desire or unsuccessful efforts to cut down or control use? **Yes/no**

Do you spend a great deal of time to obtain, use or recover from your drug of choice? Yes/no

Do you have a strong desire or craving to use alcohol or your drug of choice? Yes/no

Has recurrent use resulted in a failure to fulfill major role obligations at work, school or home? Yes/no

Do you continue to use despite persistent/recurrent social or interpersonal problems from use? Yes/no

Have you given up or reduced important social, occupational or recreational activities because of use of drugs or alcohol? Yes/no

Have you continued to drink or use drugs in situations in which it is physically hazardous? Yes/no

Have you continued to drink or use drugs despite knowledge of persistent or recurrent physical or psychological problems likely caused by your use? Yes/no

Have you noticed the need for markedly increased amounts of alcohol / drugs to achieve your desired level of effect or intoxication? Yes/no

Have you noted a diminished effect with continued use of the same amount? Yes/no

Have you had any withdrawal affects or needed to use something else to relieve or avoid withdrawal? Yes/no

Describe any legal issues with drugs, alcohol or other:

LIST age of first use, history of use and most recent use of:

Marijuana
Cocaine
Stimulants
Benzodiazepines
Sleeping aids
LSD
Inhalants
Opioids
MDMA MDMX XYZ
Other

What is your drug of choice?

DESCRIBE any psychological assessments, interventions, diagnoses or treatments in your lifetime.

Have you ever had anger management training / treatment or told you were “disruptive” at work? Yes/no

Details:

LIST details of prior work complaints or negative performance reviews you are aware of:

DESCRIBE any chronic pain issues and their management:

How much sleep do you usually get each day during the week?
on the weekend?
night shift work?

HOW do you exercise and how often?

Is your life out of balance in regards to:
( ) Sex ( ) Food ( ) Sleep ( ) Gambling/Gaming ( ) Spending ( ) Work ( ) Exercise
( ) Viewing Pornography ( ) Internet

How much time per day do you spend checking social media: **Sites?:**

What are you currently doing to maintain wellbeing, life balance and/or recovery?

DO you regularly engage in any religious or spiritual activity? ( ) Yes ( ) No
If yes, describe:

WHAT do you do for FUN?:

Describe your friendships outside of work or family?:

Current marital status: ( )single ( )married ( )divorced ( )separated ( )widowed

Describe details of prior marriages or involved relationships:

Do you have children? NO / Gender(s) and age(s)

Do you have stepchildren? NO / Gender(s) and age(s):

Is your marriage /relationship /home life:
( ) happy ( ) tolerable ( ) stressed ( ) miserable ( ) other
explain:

Describe Childhood (Briefly), include number of siblings, any childhood trauma (physical, emotional, sexual):

How does your work interfere with your family or personal interests?

With whom do you share household expenses, child care and chores?

EDUCATION

Where/when did you graduate from high school?
College? Major?

Where did you attend professional school and dates?

List your training locations with dates:

What is your current debt load from schooling? Credit cards?

Mortgage? Other debts?

What was your occupation(s) prior to professional school?

Details of current certification:

LICENSURE

LIST all states where you currently hold a professional license:

LIST the medical facilities where you have privileges or employment:

List any malpractice claims with date and current status:

Describe problems with your healthcare provider license, drivers license, legal or insurance status:

EMPLOYMENT

Primary employer:

Usual hours each week: **Usual schedule?**

Start date:

Other employer(s):

Usual hours each week: **Usual Schedule?**

Start date:

List committee work, supervisory, leadership or voluntary commitments you have:

Describe any retention or recruitment challenges in your practice or group:

Do you take call? ( ) No ( ) Yes - describe your call schedule:

How many hours of continuing education have you had this year?
Live course locations:

When and where was your last REAL vacation?

How many days of vacation do you usually take each year?

How many days / weeks of paid vacation are you entitled to?

Is your work environment:
( ) happy ( ) tolerable ( ) stressed ( ) miserable ( ) other

Explain:

What would improve your work/life?

What would improve your situation?

REASON FOR TODAY'S VISIT

Please describe why you are here today using additional space as needed:

I have answered the above questions to the best of my knowledge and I understand that this questionnaire and initial interview is to determine if further evaluation is warranted. This form is held with the strictest confidence. Please help us to help you.

____ ***Date*** ____________
Signature

NHPHP notes: