*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?**

**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 of surgical procedures and hospitalizations with dates.

**Check box and write details if you have ever been evaluated for:**

| | | |
|---|---|---|
| ☐Substance Abuse | ☐Learning Disabilities | ☐ADHD or ADD |
| ☐Ulcers | ☐Sleep apnea | ☐Panic Disorder/Anxiety |
| ☐Unexplained Weight Loss/Gain | ☐Inflammatory or IBS | ☐Seizures |
| ☐Insomnia / Problems sleeping | ☐Hearing loss | ☐Back Pain or Sciatica |
| ☐Depression | ☐Suicide attempts or thoughts | ☐PTSD |
| ☐Headaches | ☐Syncope | ☐Metabolic syndrome |
| ☐Diabetes | ☐Chronic pain | |
| ☐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:**

**DESCRIBE any chronic pain issues and management:**

***SUBSTANCE USE HISTORY***

**What is your smoking status now and in the past?**
**Circle tobacco use – patches, vaping, chewing tobacco, spray, lozenges?**

**What types of alcoholic beverages do/did you drink?**

Usual amount: How often:
Age at first drink?
Age first got intoxicated?

Have you ever been stopped or charged with a DUI? ☐**Yes** ☐**No** - 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 sx or needed to use something else to relieve or avoid withdrawal?** ☐**Yes** ☐**No**

**Describe any legal issues with drugs, alcohol or other:**

**Have you ever been jailed or incarcerated? ☐Yes ☐No**
**Details related to being jailed or incarcerated:**

**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 your family history of addiction:**

**Which family members have history of suicide, suicidal ideation, depression, anxiety, or bipolar disorder?**

**Describe any childhood trauma (physical, emotional, sexual):**

**DESCRIBE prior psychological assessments, interventions, diagnoses or treatments:**

**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:**

***HABITS***

**How much sleep do you usually get during the week?**
**On the weekend?**

**Do you ever work night shifts? ☐Yes ☐No Frequency:**

**HOW do you exercise and how often?**

**Check what in your life is out of balance or a numbing habit:**

☐Sex ☐Food ☐Sleep ☐Gambling ☐Gaming ☐Shopping

☐Work ☐Exercise ☐Internet ☐Social Media ☐Pornography

☐Other-

**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:**

**Describe details of prior marriages or involved relationships:**

**Do you have children? ☐Yes ☐No** **If yes, what are the name(s) and age(s):**

**Do you have stepchildren? ☐Yes ☐No** **If yes, what are the name(s) and age(s):**

**Describe your childhood including birth order and number of siblings:**

**Is your current marriage /relationship /home life:**

☐happy ☐tolerable ☐stressed ☐miserable ☐other
explain:

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

**With whom do you share household expenses, childcare and chores? Pets?**

***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, driver's license, legal or insurance status:**

***EMPLOYMENT***

**Primary employer:**

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

**Primary Employer 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 work setting:**

**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?**

***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***