New Hampshire Professionals Health Program
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Initial Interview Questionnaire

Molly Rossignol DO
Medical Director

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Assistant Medical Director

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Clinical Coordinator

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:

Emergency Contact: **Relationship:** **Phone:**
Email:

Name and contact numbers of the following as applicable:

Treating physician: Phone #:

Psychiatrist: Phone #:

Therapist/counselor: Phone #:

Legal representative: Phone #:

Over the past two weeks:
How often have you felt down, depressed or hopeless?
Not at all ____ Several days____ More than half the days ____ Nearly Every Day____
Little interest or pleasure in doing things?
Not at all____ Several Days___ More than half the days ____ Nearly Every Day___

If you feel that you are at risk of harming yourself or thinking of suicide, please call 1-800-273-8255 (talk) or text HELLO to (741741)

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?

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 on the next page 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