MAINE MEDICAL ASSOCIATION
MEDICAL PROFESSIONALS HEALTH PROGRAM

Intake Questionnaire

*Name*_____ *Date*_____

Medical:

Do you have a primary care provider? [ ] Yes [ ] No

Are you treated for any physical medical conditions? If yes, please list:

_____

_____

_____

Are you currently being treated for chronic pain? [ ] Yes [ ] No

Are you currently under the care of a specialist? [ ] Yes [ ] No

Current medications (name, dose, frequency. Include both prescribed and OTC):

_____

_____

_____

_____

On average, how many hours sleep do you get per night? _____

Do you consider it restful sleep? [ ] Yes [ ] No

Have you had bariatric surgery? [ ] Yes [ ] No

Mental health and substance use:

Do you have a mental health or substance use diagnosis? If yes, please describe.

_____

_____

_____

_____

Have you ever received treatment by a mental health professional? [ ] Yes [ ] No

Are you receiving treatment now? [ ] Yes [ ] No

Does anyone in your immediate family (parent, sibling, children) suffer from a mental health or substance use disorder? [ ] Yes [ ] No

If yes, please describe:

_____

_____

_____

_____

_____

Do you live with anyone who suffers from mental health issues, substance use concerns, or chronic pain? If yes, please describe.

_____

_____

_____

_____

_____

Have you experienced trauma in your life? If yes, please explain.

_____

_____

_____

_____

_____

_____

Are there any other challenges that are impacting your life currently? If yes, please explain.

_____

_____

_____

_____

_____

Please indicate your pattern of use for each of the following, if any:

Substance	**Date last used**	**How often do you use it?**	**Amount used currently**	**Age of 1st use**	**Age became problem (if applicable)**
Alcohol					
Marijuana					

Opiates					
Benzodiazepines					
Stimulants					
Other:					

Do you experience any withdrawal symptoms when trying to quit any of these substance, if applicable? [ ] Yes [ ] No

If yes, please describe:

_____

_____

_____

Are there any other behaviors you are involved in that have created problems for you (ex: eating disorder, OCD, cutting, skin picking, gambling, spending, sex, work? [ ] Yes [ ] No

If yes, please describe:

_____

_____

_____

_____

What do you currently do to maintain over health and wellbeing?

_____

_____

_____

_____

Legal:

Current status: [ ] Clear [ ] Probation [ ] Parole [ ] Deferred [ ] Pending

Please list any criminal charges, convictions, dates, and outcomes:

_____

_____

_____

_____

Have you ever participated in DEEP? [ ] Yes [ ] No

Have you ever been accused of perpetrating domestic violence? [ ] Yes [ ] No

Have you ever been accused of a non-DV violent offense? [ ] Yes [ ] No

Employment:

Overall how satisfied are you with your current employment status?

[ ] Very satisfied [ ] Satisfied [ ] Neutral [ ] Dissatisfied [ ] Strongly dissatisfied

If you are dissatisfied or strongly dissatisfied, what would you like to see change?

_____

_____

Are you able to concentrate at work? [ ] Yes [ ] No

Do you feel appreciated at work? [ ] Yes [ ] No

Do you get along with your coworkers? [ ] Yes [ ] No

Do you feel stimulated by your profession? [ ] Yes [ ] No

Please list any employment terminations or disciplinary actions:

_____

_____

_____

Please list any malpractice claims, including outcomes:

_____

_____

Are you now, or have you ever, been involved with a PHP? [ ] Yes [ ]No

Where and why?

_____

*Please sign below to signify that you have read and understand the contents of this form and have reviewed the information with the Clinical Coordinator.

Participant Signature_____Date_____

Clinical Coordinator Signature_____Date_____