PARTICIPANT DEMOGRAPHIC & INTAKE FORM

ndphp.ORG
Your partner in the process

Full Name of Prospective Participant (Please attach your CV)

Last: _____ First: _____Middle: _____

Date of Birth: _____ SS#: _____

Degree: MD DO PA OTHER _____Specialty _____

Spouse/Significant Other: _____

Contact #_____

Home Address:

Street _____

City _____ State _____ Zip _____ County _____

Office Address:

Street _____

City _____ State _____ Zip _____ County _____

I prefer to receive NDPHP correspondence at my _____ home address _____ office address

Phone: Home_____ Cell_____
Office_____ Pager_____
Email: _____

Medical License number(s) and status of license(s): *(Use reverse if additional space is needed.)*

State_____ Number_____ Status_____
State_____ Number_____ Status_____
State_____ Number_____ Status_____

Primary Care Physician:

Name _____ Degree MD DO

Address where NDPHP correspondence for PCP is to be mailed:

PARTICIPANT DEMOGRAPHIC & INTAKE FORM

Street _____

City _____ State _____ Zip _____ County _____

Phone: _____ Email Address _____

Monitor: (Please attach Monitor's CV) *(if applicable.)*

Name _____ Degree MD DO

Address where materials and correspondence for Monitor are to be mailed:

Street _____

City _____ State _____ Zip _____ County _____

Phone: _____ Email Address _____

Past and/or Present Medical Board, Court System, State or Hospital Monitoring Program involvement: *(use reverse if additional space is needed.)*

Name _____

Dates _____

Contact Person _____

Street _____

City _____ State _____ Zip _____

Phone: _____ Email Address _____

Name _____

Dates _____

Contact Person _____

Street _____

City _____ State _____ Zip _____

Phone: _____ Email Address _____

Name _____

Dates _____

Contact Person _____

PARTICIPANT DEMOGRAPHIC & INTAKE FORM

Street _____

City _____ State _____ Zip _____

Phone: _____ Email Address _____

Medical Liability Insurance Information:

Name _____

Attorney (if applicable):

Name _____

Contact Person _____

Street _____

City _____ State _____ Zip _____

Phone: _____ Email Address _____

MEDICATION RECORD

No.	Medication	Dosage	Purpose	Prescribing Physician
1				
2				
3				
4				
5				

(Use separate page if additional space is needed.)

Past or Present Treatment Program(s): *(Use separate page if additional space is needed.)*

Drug(s) of abuse (include all) _____

Sobriety Date _____

Name _____

Admission/Discharge Dates _____

Contact Person _____

Street _____

City _____ State _____ Zip _____

Phone: _____ Email Address _____

PARTICIPANT DEMOGRAPHIC & INTAKE FORM

Name _____

Admission/Discharge Dates _____

Contact Person _____

Dates _____

Street _____

City _____ State _____ Zip _____

Phone: _____ Email Address _____

Past (within 10 years) and/or Present Therapist(s): *(Use separate page if additional space is needed.)*

Name _____ Degree/Credentials _____

Street _____

City _____ State _____ Zip _____ County _____

Phone: _____ Email Address _____

Treatment Date(s) _____

Purpose _____

Name _____ Degree/Credentials _____

Street _____

City _____ State _____ Zip _____ County _____

Phone: _____ Email Address _____

Treatment Date(s) _____

Purpose _____

Any additional person/organization that you think would be beneficial or necessary for NDPHP to contact on your behalf: *(Use separate page if additional space is needed.)*

Name _____

Street _____

City _____ State _____ Zip _____

Phone: _____ Email Address _____

Name _____

PARTICIPANT DEMOGRAPHIC & INTAKE FORM

Street _____

City _____ State _____ Zip _____

Phone: _____ Email Address _____

Name _____

Street _____

City _____ State _____ Zip _____

Phone: _____ Email Address _____

I am presently employed _____ Unemployed _____

I am _____ a resident _____ a solo practitioner _____ in a group practice _____ an employee

I found out about NDPHP from _____

-or-

I was referred to NDPHP by _____

_____ _____

Signature Date

** Please attach copies of any medical board, court, monitoring or treatment records, especially assessment and discharge summary/recommendations you may have in your possession. If these are available to you, please contact the facility or agency and request that your records be forwarded to NDPHP.**

Comments or questions:

_____

_____

_____

_____

_____

Thank you,

ND Professional Health Program