WEST VIRGINIA DISCIPLINARY ALTERNATIVE PROGRAM FOR IMPAIRED REGISTERED PROFESSIONAL NURSES

INTAKE FORM

Date Completed: _____ Completed By:_____

Name:_____ Date of Birth:_____

Home Phone:_____ Work Phone:_____

Mailing Address:_____

_____

Sex: Male Female Registered Nurse License #_____
Date Issued:_____

Person to contact in case of emergency:

Name/Relationship:_____

Address: _____

Phone:_____

Are you licensed in any other state? Yes No

If yes, name state(s) and provide license numbers:

_____

_____

A. Treatment Readiness

1. What brought you to the Impaired Professionals Program?

_____

_____

_____

_____

2. What expectations do you have?

3. Do you have an alcohol, drug or severe emotional problem? yes no
If yes, please describe:

Alcohol:

Drug:

Emotional:

4. Do your family and friends think you have an alcohol, drug or severe emotional problem? yes no
If yes, please describe.

5. How has this problem affected your immediate family?

6. How has this problem affected other areas of your life?

7. Please list any situations that are significantly impacting your life at this time.

B. Personal Status

1. Describe your biological family background. (Parental and sibling relationships, both past and present, where you were raised, parent's occupation, etc.) If you grew up in a family other than your biological family please discuss that.

2. Do other persons or family members live with you? Yes No If yes, please describe.

3. Current Marital Status: Married Single Widowed Divorced Separated

Name of Spouse or Cohabitant:

4. Do you have children? Yes No

If yes, please list names, ages, describe relationships with, and indicate if they are living at home or away from home.

C. CURRENT LIVING SITUATION

1. With whom are you currently living?

2. Does anyone in your family or a significant other have a drinking/substance abuse problem? Yes No

If yes, relationship:

D. PHYSICAL/MEDICAL HISTORY

1. Are you on any medication? Yes No
Please list.

2. Are you currently being treated by a physician? Yes No

For what reasons or conditions:

_____

Physician's name, address and phone number:

_____

For what reasons or conditions:

_____

Physician's name, address and phone number:

_____

For what reasons or conditions:

_____

Physician's name, address and phone number:

_____

For what reasons or conditions:

_____

Physician's name, address and phone number:

_____

E. EMOTIONAL/PSYCHOLOGICAL HISTORY

1. Have you ever received counseling/therapy services? Yes No

If yes, explain situation and date: _____
_____
_____
_____

2. Are you currently seeing a counselor/therapist? Yes No

How often: _____
Counselor: _____
Address: _____
Phone: _____

3. Have you ever been hospitalized for drug, alcohol, psychological or psychiatric reasons? Yes No

If yes:

Dates Facility Circumstances

_____
_____
_____
_____

4. Have you ever overdosed? Yes No

5. If yes:

Date Drug Used How Treated Circumstances

_____
_____
_____
_____

6. Have you ever felt suicidal? Yes No
Do you feel suicidal now? Yes No
Have you ever attempted suicide? Yes No
If yes, how many times? _____

Please describe date, type of attempt and reason for the attempt:

_____
_____
_____
_____

Where you under the influence of drugs or alcohol at the time? Yes No

7. Do you have a diagnosed psychiatric disorder? Yes No

If yes, describe:

_____
_____
_____
_____

Are you currently being medicated for this diagnosis? Yes No

Medication: _____
Dosage: _____
Frequency: _____
Physician: _____
Address: _____
Phone No.: _____

F. SOCIAL HISTORY

1. Briefly describe peer relationships?

_____
_____
_____
_____

2. What type of social/community activities are you involved in?

_____
_____
_____
_____

3. Professional Associations? List and describe.

_____
_____
_____
_____

4. Hobbies? Yes No

Describe:

_____
_____
_____
_____

G. LEGAL HISTORY

1. Have you ever been arrested? Yes No

If yes, were you under the influence of alcohol or other drugs at the time? Yes No

2. Please describe your arrests. Include the following information for each arrest: date, all charges, whether charges were misdemeanor or felony charges, whether you were convicted or not, the current disposition of your case, final outcome and upcoming court dates.

_____
_____
_____
_____

3. Have you been contacted by DEA? Yes No

4. Are you on probation or parole? Yes No Which one?

Federal _____ State _____ County _____

Length of Sentence _____
How much served to date _____

Name of probation/parole officer _____
Address _____ Phone Number: _____

5. Are you currently under investigation by your licensing board? Yes No

6. Has your nursing practice ever been monitored for any reason, disciplinary action or otherwise, by any facility, board or group? Yes No

If yes, when and in which states and what action:

_____
_____
_____
_____

7. Do you have an attorney involved in any of the above? Yes No

Name _____
Address _____
Phone No. _____

H. VOCATIONAL HISTORY

1. What is your area of specialization? _____
2. Date you first became licensed? _____

3. Are you currently employed? _____

_____
Name

_____
Address _____

_____
Phone No.

4. Employed as: _____

5. How long have you held current position? _____
6. Current title, or position? _____

7. Overall satisfaction with current position?

_____

8. If unemployed, for how long? _____

9. Describe last position? _____

10. Why did you leave? _____

11. Are you presently looking for work? Yes No
If yes, what type?
_____

12. What is the longest period you have held a job? ___

_____

13. List all jobs in your profession over the past 10 years beginning with your most recent:

a. Dates of Employment
_____
Institution Name
_____
Type of Employment
_____
Reason for Leaving
_____
Asked to Resign Yes No
Resigned Yes No
Terminated Yes No

b. Dates of Employment
_____
Institution Name
_____
Type of Employment
_____
Reason for Leaving
_____
Asked to Resign Yes No
Resigned Yes No
Terminated Yes No

c. Dates of Employment
_____
Institution Name
_____
Type of Employment
_____
Reason for Leaving
_____
Asked to Resign Yes No
Resigned Yes No

Terminated Yes No

d. Dates of Employment

_____
Institution Name

_____
Type of Employment

_____
Reason for Leaving

_____
Asked to Resign Yes No
Resigned Yes No
Terminated Yes No

e. Dates of Employment

_____
Institution Name

_____
_____
Type of Employment

Reason for Leaving

_____
Asked to Resign Yes No
Resigned Yes No
Terminated Yes No

f. Dates of Employment

_____
Institution Name

_____
Type of Employment

_____
Reason for Leaving

_____
Asked to Resign Yes No
Resigned Yes No
Terminated Yes No

g. Dates of Employment

_____
Institution Name

_____
Type of Employment

_____
Reason for Leaving

_____
Asked to Resign Yes No
Resigned Yes No

Terminated Yes No

14. Overall satisfaction with career choice?
Dissatisfied Fairly Satisfied Very Satisfied

15. Future Career
Goals?_____

I. CHEMICAL USE HISTORY

1. First became concerned about drinking at age: _____
_____

2. First became concerned about drug use at age: _____

3. Drinking/drug use first began to interfere with your life at age: _____

4. How does your personality change when you drink/when you use drugs?
_____
_____
_____

5. Date of last drug use: _____

6. Date of last alcohol use: _____

7. Have you ever had a black out? Yes No If yes, describe.
_____
_____
_____

7. Do you think you should cut down on drinking? Yes No

8. Do you attend Self Help, 12 step group attendance for drugs or alcohol (AA, NA, CA, RR, etc.)

Organization _____

Location_____

Frequency _____
_____

J. RELAPSE HISTORY

How many times have you relapsed after a period of sobriety? Describe each occurrence, including dates and circumstances.

It is essential that you provide us with an accurate and complete history of all the mood/mind altering chemicals that you have used including prescription, hospital, pharmaceutical and street drugs. Please use this information/code sheet to assist you in filling out the following two pages of questions.

SEVERITY OF PROBLEM: List each substance under the appropriate column. Begin with the “Primary Substance Problem”. There can be only one each of the primary, secondary, and tertiary substances. The primary substance is the one which has caused you the most serious health, social or other problem. List a secondary substance only if you have entered a primary substance. List a tertiary substance only if you have entered a primary and secondary substance.

ROUTES OF ADMINISTRATION: The following is a list of the various routes of administration. List all the routes of administration that you have used for each substance entered.

Intramuscular	PO Liquid	Smoke	Subcutaneous
Intravenous	PO Solid	Snort	Other

FREQUENCY: Specify the average number of times (frequency) you used the substance from among the following choices.

< 1 time/month	1-4 times/month	1-2 times/week	3-5 times/week
> 5 times/week	1-3 times/day	3-5 times/day	> 5 times/day

DOSAGE: Estimate the average dosage you used each “time” you used the substance and select a measure appropriate to that substance.

1. First list all of the substances you have ever used across the top of this and the following pages. Answer the remaining questions for all substances which you used in the 24 months prior to your entry into the Program. (If the substance was not used during this 24 month period, you are required only to list the substance).

	Primary Substance Problem	Secondary Substance Problem	Tertiary Substance Problem
Substance:			
Dates Used From - To:			
Route(s) of Administration:			
Dosage Used:			
Frequency:			
Cost Past Year:			
Age of First Use:			
Age of First Intoxication:			
Age Regular Use Began:			
Longest Period Of Abstinence:			
Age Obtained:			

Use for other Substances:

	Primary Substance Problem	Secondary Substance Problem	Tertiary Substance Problem
Substance:			
Dates Used From - To:			
Route(s) of Administration:			
Dosage Used:			
Frequency:			
Cost Past Year:			
Age of First Use:			
Age of First Intoxication:			
Age Regular Use Began:			
Longest Period Of Abstinence:			
Age Obtained:			