Desert Wise, LLC • 1201 Eubank Blvd NE, Ste. 1 • Albuquerque, NM 87112

Fitness for Duty Questionnaire for UNM Residents

Please fill out form completely. If an item does not apply write "N/A." Do not write in the shaded areas.

1. General Information

Today's Date: (MM/DD/YYYY)		DOB: (MM/DD/YYYY)	Age:
Patient Name:		Gender:	Ethnicity:
Street Address:			Social Security Number:
City, State, Zip Code:			
Home/Cell Phone:	Can a voicemail from Dr. Henrie be left on this phone? ☐Yes ☐No	Work Phone:	Can a voicemail from Dr. Henrie be left on this phone? ☐Yes ☐No
Email:		Can Dr. Henrie email you? ☐Yes ☐No *(As noted in Desert Wise's Informed Consent, email is not considered a confidential form of communication.)*	
List any concerns you have about confidentiality/privacy/your patient rights:		Do you understand that Dr. Henrie will provide recommendations to your department regarding your ability to work? ☐Yes ☐No	
Did you receive a copy of Dr. Henrie's Privacy Policy? ☐Yes ☐No		Do you agree that Dr. Henrie has permission to provide recommendations to your department at UNM? ☐Yes ☐No	
Emergency Contact Name:	Relationship to You:	Emergency Contact Number(s):	

2. Primary Concern/Problem

	Provider use only:
Describe the primary concern/problem that caused your leave of absence from residency:	
When did this concern/problem start?	
What, if anything, caused or was associated with the start of this concern/problem?	
Has the concern/problem gotten worse, better, or stayed about the same over time?	
What solutions, if any, have been helpful in resolving this concern/problem?	
What solutions, if any, have not been helpful in resolving this concern/problem?	
What has changed that makes you feel you are able to return to work now?	
Who do you prefer to confide in?	

3. Psychological Functioning

Question	Yes	No	*Provider use only*:
In a single word, describe your mood over the past 2 weeks:			
Are you currently feeling helpless or hopeless? If so, please describe:	Yes ☐	No ☐	
Over the past week, have you had thoughts of killing yourself?	Yes ☐	No ☐	
Over the past week, have you had thoughts of killing someone else?	Yes ☐	No ☐	
Have you *ever* intentionally tried to kill yourself?	Yes ☐	No ☐	
Have you *ever* intentionally cut, burned, or otherwise harmed yourself?	Yes ☐	No ☐	
Has anyone close to you ever completed suicide?	Yes ☐	No ☐	
Do you currently own a firearm or plan to acquire one?	Yes ☐	No ☐	

4. Mental Health History

Question	Yes	No	*Provider use only*:
Have you *ever* received counseling or other mental health/substance abuse treatment? If yes, please describe:	Yes ☐	No ☐	
Have you *ever* been hospitalized for psychiatric reasons? If yes, please describe:	Yes ☐	No ☐	
Have you *ever* been prescribed medications to change your mood, thoughts, behaviors, or sleep (irrespective of who prescribed the medications)? If yes, please list names & timeframes of medications:	Yes ☐	No ☐	
Does anyone in your family have a history of substance abuse, depression, or any other mental health condition? If yes, please describe:	Yes ☐	No ☐	
Are you currently under the care of a psychiatrist? Name of your psychiatrist:	Yes ☐	No ☐	

5. Medical History

Question	Yes	No	*Provider use only*:
Do you have any serious and/or chronic medical diagnoses? If yes, please list:	Yes ☐	No ☐	
Have you *ever* had any surgeries? If yes, please list:	Yes ☐	No ☐	
Are you currently taking any prescription, over the counter, supplements, or herbal medicines? If yes, please list:	Yes ☐	No ☐	
Do you have any food or drug allergies? If yes, please list:	Yes ☐	No ☐	
Are you currently experiencing any chronic pain? If yes, where? Rate this pain: (No Pain) 0 1 2 3 4 5 6 7 8 9 10 (Worst Imaginable Pain)	Yes ☐	No ☐	

Name: DOB: LAST 4 OF SSN:

6. Personal and Social History

Where were you born?	Where were you raised?		*Provider use only*:
Who were you raised by?	Number of Siblings:	Birth Order Number:	
Are your parents divorced? ☐Yes ☐No If yes, how old were you?	Were you adopted? ☐Yes ☐No If so, at what age?	Were you ever placed in foster care? ☐Yes ☐No If so, at what age?	

Question	Yes	No
In the last year, have you been physically hurt or abused?	☐	☐
Have you *ever* been in an abusive relationship? If yes, when?	☐	☐
Did you experience any abuse in childhood?	☐	☐
Have you *ever* had legal problems? If yes, please describe:	☐	☐
Have you *ever* had financial problems? If yes, please describe:	☐	☐

7. Immediate Family

Are you married? ☐Yes ☐No	How many total times have you been married?	*Provider use only*:
Have you had a spouse precede you in death? ☐Yes ☐No If so, when?	If married, spouse's name and age:	
If not married, are you currently in a relationship? ☐Yes ☐No *(If no, skip to section about children.)*	Length of current marriage or relationship:	
How would you rate your overall satisfaction with your marriage/relationship? (Very Unsatisfied) 1 2 3 4 5 (Very Satisfied)		
What challenges, if any, do you have in your relationship?		
What strengths do you have in your relationship?		

If you have children, please list them below:

Child's Name	Age	Special Needs, if any:	Gender		Living with You?		Is this your stepchild?	
			M	F	Yes ☐	No ☐	Yes ☐	No ☐
			M	F	Yes ☐	No ☐	Yes ☐	No ☐
			M	F	Yes ☐	No ☐	Yes ☐	No ☐
			M	F	Yes ☐	No ☐	Yes ☐	No ☐
			M	F	Yes ☐	No ☐	Yes ☐	No ☐

Is there anyone else currently living in your home? ☐Yes ☐No
If yes, please list:

8. Group Identities

Question	N/A	Yes	No	*Provider use only*:
Do you have any continued involvement in religious or spiritual activities? If yes, what is your affiliation?		☐	☐	
Do you have any religious practices or concerns that may alter your care? If yes, please describe:		☐	☐	
If you are no longer involved in religious or spiritual activities, but you have a past faith-based affiliation that is important to your care, please mark yes:	☐	☐	☐	
Do you have a cultural affiliation that is important to your identity? If yes, what is your affiliation?		☐	☐	
Are there any other affiliations or aspects of your identity that are important to your care? If yes, please list and/or describe:		☐	☐	

9. Education and Occupation

Question	Yes	No	*Provider use only*:
What is the highest level of education you have completed?			
If you have completed any college, please list your major(s)/degree(s):			
Did you have any learning or behavioral problems while in school? If yes, please describe:	☐	☐	
What residency/department are you in?			
How would you rate your overall satisfaction with your current job? (Very Unsatisfied) 1 2 3 4 5 (Very Satisfied)			
What challenges, if any, do you have in your current job?			
What strengths do you have in your current job?			
What are your long-term career goals?			

Name: DOB: LAST 4 OF SSN: