Alabama Physician Health Program

MEDICAL ASSOCIATION of the STATE of ALABAMA
19 S. Jackson St., Montgomery, Alabama 36104
334 954-2596 (Office) staff@alabamaphp.org (Email) 334 954-2593 (FAX)

Quarterly Self-Assessment Report

(To be completed by participant and provided to Monitoring Professional – quarterly)

_____ _____ _____

Participant (signature) **(please print name)** **Date**

1. **What is your sobriety date/last use?_____**
2. **Has your sobriety date changed since your last quarterly report? _____Yes _____No**
3. **Drug(s) of choice: _____**
4. **Current Medications: _____**
5. **Describe any thoughts or tendencies toward compulsive or disruptive behavior (Sex, food, gambling, spending, drugs, or specify):**
6. **Quality of Life - Describe current challenges in each area.**

   Work:

   Home:

   Family:

   AA/Meetings:
7. **Indicate (as accurately as possible) times per month you engage in the following recovery activities:**

   _____Attend 12 step meetings

   _____Attend Therapeutic Monitoring group meetings

   _____Attend Caduceus group meetings

   _____Contacts with your 12 step sponsor

   _____ Name & Phone of Sponsor

   _____ Name and Phone Number of Worksite Monitor

   _____Attend individual therapy or counseling sessions

   Evidence of your attendance at meetings may be required.
8. **Random urine testing is being performed and specimen collection is always observed by lab personnel? ___yes___no**

_____ _____ _____

Signature of Monitoring Physician * (please print name) Date

*Note to monitor: Please make any comments on the backside of this form then send to APHP.
Mail to: 19 S. Jackson St., Montgomery, AL 36104 or FAX to: 334-954-2593