Mississippi Physician Health Program

MPHP INTAKE FORM

(Please do not leave any section blank.)

Name: **Date:**

Date of Birth:

SS#:

Home Address:

Home phone number: **Cell phone number:**

Email:

Name, address, and phone number of spouse or significant other:

Name and phone number for emergency contact person at work:

Name and phone number for additional emergency contact person:

PRACTICE INFORMATION:

Specialty:

List ALL State(s) where license held: Primary: Other:

Status of MS license: Active Inactive Out of State Retired Unlicensed

Primary Medical (Other) School Attended: Grad Year:

Residency: Grad Year:

Residency: (other specialties) Grad Year:

Employer/Practice name, address and phone number:

Hospital Where You Have Staff Privileges:

Are you supervising, or in collaboration with, Nurse Practitioners? Yes or No

If yes, indicate number _____ and setting(s) _____

MSMA Member: Yes or No

PRIOR TREATMENT, THERAPY, EVALUATION, OR PSYCHIATRIC HOSPITALIZATION(S)

For each treatment, include: 1. Facility Name(s), 2. Dates of treatment, 3. Diagnosis, 4. Duration of treatment, and 5. Discharge status (e.g., AMA discharge, or appropriate discharge)

List all Psychiatric Diagnosis or Comorbidity (Dual Diagnosis):

Axis I:

Axis II:

List ALL substances abused:

Date of Sobriety:

HEALTH CARE PROVIDER INFORMATION:

(Include name, address and phone number for each.)

Primary Care Physician:

Psychiatrist (if applicable):

Therapist (if applicable):

Prescription Medications, Dose and Frequency:

REASON FOR MPHP CONTACT (WHY YOU ARE HERE)

(Please use additional sheet, if necessary.)

Participant Signature: _____