OHIO PHYSICIANS HEALTH PROGRAM
Quarterly Information Form

YOUR NAME: _____ **PARTICIPANT ID:** _____

Months covered by this report: (circle appropriate months)

Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec

I am in compliance with all terms of my OPHP Agreement. _____ (initial)

I have maintained abstinence and I have not used any mood altering chemicals (over-the-counter or controlled) other than those prescribed for me for medical purposes. _____ (initial)

I certify that my Urine Drug Tests are collected under Direct Observation. _____ (initial)

LAST THREE MONTHS ACTIVITIES

This list is intended to assist in personal reflection of recovery and wellness activities.

1. Average weekly meeting attended (including Caduceus) **> 5 5 4 3 2 1**

2. Weekly aftercare meeting attendance (if applicable) **Yes _____ No _____ NA _____**

3. Weekly Sponsor contact frequency **Direct: daily 5 3 1 less than 1**
Phone: daily 5 3 1 less than 1

4. Counseling (If applicable) **NA _____ No _____ Yes _____ (If yes, frequency) _____**

5. Working which step (if applicable) _____

6. Physical exercise **No _____ Yes _____ (If yes circle # of times per week) 1 2 3 4 5**

7. Do you pray / meditate? **Yes _____ No _____**

8. Do you journal? **Yes _____ No _____**

9. Times per week spent with family/friends/significant other(s) **daily 5 3 1 less than 1**

10. Average number of work hours per week **less than 20 20-30 30-40 40-50 50-60 greater than 60**

11. Do you feel your life is balanced? **Yes _____ No _____**

12. Briefly describe service activities over the last three months: _____

_____

13. Social Support: _____

_____

14. Comments: _____

_____

I would appreciate an OPHP contact: **Yes _____ No _____**

Signature: _____ Date: _____