



NEW MEXICO HEALTH PROFESSIONAL WELLNESS PROGRAM

Confidential Monthly Self-Report Form
Due by the 10th of the month following the report month
Please make copies for future use
Month report is for: _____

Name _____ HPWP # _____ Prof _____ Date _____

Address _____ City _____ State _____

Home Phone _____ Work phone _____ Cell phone _____

Spouse (SO) _____

Employment (Employer) _____
Work Site Monitor _____ Title _____
Phone # _____ How often do you see this person _____

Recovery: Type (AA/NA) _____ meetings & type per week _____
Sponsor (first name last initial) _____ Length been sponsor _____
How often do you see your sponsor outside of meetings _____
What step are you currently working _____ Service _____

Drug Screen Testing: Color _____ # of tests in reporting month _____

Treatment:
Counseling Group: Facilitator _____ # of meetings held _____
#attended this month _____
Psychiatrist _____ Phone # _____ Freq of visits _____
Therapist _____ Phone # _____ Freq of visits _____

List all medications you are taking either prescribed or over-the-counter (use back of form for additional space)

Medications _____	Dose _____	Freq _____
Medications _____	Dose _____	Freq _____
Medications _____	Dose _____	Freq _____
Medications _____	Dose _____	Freq _____
Medications _____	Dose _____	Freq _____

Events of the month: (Please write about your recovery, events, accomplishments, problems, etc)

Use back of form for more space.
MTP staff encourage you to keep copies of this report and all other reports you send to MTP.