

Confidential Health Inventory

Please answer the following questions. Please note that while there is space set aside for your responses to open ended questions the space provided is not meant to limit your response. Feel free to use separate paper, a word processor or whatever written manner or form that is easiest for you. Also, if more then one response or experience comes to mind and you are willing to share that, feel free to do so. Thank you.

General information

Occupation _____ Employer _____ Years _____

Employment Status: Full-Time Part-Time School Retired Unemployed

Other _____

Law Enforcement Fire EMS 911 Dispatch RN MD Ph.D. Military

Air Support/Rescue MEU/Coroner Jail/Corrections Federal _____

Alcohol/Tobacco/Firearms Drug/Enforcement Search/Rescue U.S. Customs

U.S. Marshall Other _____

Reserves _____

Education High School GED Some College College Graduate School

Degree obtained? Yes No Please specify _____

Past Military Service:

Air Force Army Marines Navy Coast Guard

Other _____

How many years active duty? _____ Deployments? Yes No

(Please specify) _____

Reserves? Yes No _____ Deployments? Yes No (Please

Specify) _____

Current Assignment (Check all that apply)

Patrol Detective Supervisor Command Staff Civilian _____

Arson Admin/Human Resources Air Support Auto Burglary Canine

Emergency Services Fire Prevention Forensic/Lab Gangs Homicide Vice

Internal Affairs/SID _____ Juvenile _____

Photographer Robbery Sex Crimes SWAT Traffic/Motor Vice/Narcotics

Specialized Assignment not listed _____

Reserve _____

911 Dispatch

Radio Dispatch only Emergency Board 911 only 911/Radio Combined

Police/Fire/EMS Police/Fire Fire only Police only EMS only

Supervisor/ Watch Commander Training Instructor Reserve

Other _____

EMS

EMT-Basic EMT-Intermediate Paramedic Search and Rescue Reserve

Other _____

Living Situation

Alone Friend(s) Partner Spouse Parents Other _____

Names and Ages of those living with you _____

Pets: _____

Status: Single Married Partnered Divorced Widowed

Other _____

Name of Partner/Spouse/Parent _____ Occupation: _____
(Circle one)

Religious/ Spiritual Preference _____

Educational background _____

How did you hear about Dr911.com: Phone Book Website Ad Friend Co-worker

Course/Seminar taught by _____ Physician/Professional _____

Articles Written by or referring to _____ Other _____

OTHER PAST MEDICAL CONDITIONS

- Childhood diseases: German measles Chicken Pox Other _____
- Heart Trouble _____ High blood pressure Stroke Varicose Veins
- Phlebitis Clotting Defects Bleeding tendencies Blood transfusion Diabetes
- Kidney trouble Rheumatic fever Jaundice/hepatitis Epilepsy Fractures _____
- Cancer _____ Arthritis Colitis Asthma
- Chronic Fatigue/Epstein Barr Eating Disorder Other
-

HABITS

Dietary preferences/restrictions: _____

Sample of day's menu:

Breakfast: _____

Lunch: _____

Dinner: _____

Routine physical exercise: Type of exercise: _____

For how many minutes? _____ How often? _____

Tobacco use (how much): _____ Previously? _____ How much? _____

How long? _____

Alcohol use (how much): _____ How often? _____

Caffeine use (how much): _____ Mood-altering substance use (i.e. marijuana, cocaine- past and present) _____

STRESSES

Stresses (family, work, self, etc.) _____

- Workplace violence Fatalities? Multiple Wounded? No injuries to person
 Other _____
-

Were you or have you ever been an off duty victim to any of the above listed events? Yes No
Please describe

Violence in Public Setting

Where you the first responder, or the victim, in any of the following situations in which violence was perpetrated in a public setting (for example: workplace violence, Columbine School Shooting, please check all that apply)

Were you the:

- First Responder/First Point of Contact Direct Relative of First Responder
 Victim Direct Relative of Victim Direct Relative of Perpetrator Other (please elaborate)

Location:

- School Church Playground Public (i.e. shopping mall, restaurant, etc.)
 Military Base Government Fire, hospital, police HQ, etc.
 Other _____
-

Intended Victims

- Child/Infant
- Adolescent
- Adult
- Elderly
- Known
- Unknown

Perpetrator

- Known _____
- Unknown

Debriefing

- Provided
- Not Provided
- Follow Up also provided

Did you feel the debriefing experience was useful? Yes No If No, Why Not?

Post Traumatic Stress Disorder/Acute Stress (PTSD)

Have you ever been diagnosed with PTSD or Acute Stress?..... Yes No
Work related?..... Yes No

Describe the event(s)

Did you obtain or receive treatment or was any type of intervention provided?..... Yes No

What kind? (Please list) _____

In your opinion was this helpful or effective?..... Yes No

If it was not helpful, why?

In your opinion what would have worked or been helpful?

Was media attention on this event significant? Yes No

Please specify your concerns

What would you do differently?

Were your family and/or friends effected? Yes No

How? (Please specify)

Have they recovered? Yes No

Had you ever been diagnosed with PTSD before?..... Yes No

If yes, when and why? _____

Social and Familial History

Alcoholism, High Blood,
Pressure, Cancer, Diabetes,
Heart Disease, Osteoporosis,
Other addiction, other illness
(Include psychiatric)

Mother _____
Father _____
Sister (s) _____
Brother (s) _____
Maternal Grandmother _____
Paternal Grandmother _____
Maternal Grandfather _____
Paternal Grandfather _____
Paternal Aunt(s) _____
Maternal Aunt (s) _____
Maternal Uncle(s) _____
Paternal Uncle(s) _____
Others _____

REVIEW OF SYSTEMS

Check any symptoms of present significance. (If any past problems, please note under Past medical problems.)

GENERAL PHYSICAL

Fever or chills Hot flashes Unusual hair growth/loss Skin eruptions Weight change

ABDOMEN

Bloating Heartburn, indigestion Cramps or pain Nausea or vomiting Change in bowel habits Bloody or tarry stools Diarrhea Constipation Hemorrhoids Flatulence

HEAD

- Headaches Dizziness Visual Defects Hearing Defects Sinus trouble
- Fainting spells

BLADDER

- Frequent urination Painful urination Blood in urine Inability to hold urine
- Inability to empty bladder Need to get up at night to urinate

CHEST

- Chest pain Shortness of breath Heart murmur Mitral valve prolapse Palpitations
- Chronic blood Coughing up blood Wheezing

BREASTS

- Lumps Bleeding Discharge Tenderness

Are you sexually active? Yes No Do you have intercourse? Yes No

Do you practice safe sex? Yes No

Any sexual concerns to discuss? _____

Any past history of sexually transmitted disease? Yes No _____

Any history of DES exposure? (DES was a drug taken by mothers during pregnancy to prevent miscarriage.) _____

COMMENTS OR OTHER CONCERNS

DAILY LIVING PROFILE

Please read the following statements which relate to your current life at home and work, and indicate whether each statement does or does not describe part of your current life by placing an "X" in the "yes" or "no" box at the right of the statement. This questionnaire is designed to increase your awareness of the effects of your lifestyle and stresses on your physical well being.

NEIGHBORHOOD STRESSES

1. My neighborhood is too noisy Yes No
2. My neighborhood is too crowded Yes No
3. My neighborhood is too quiet Yes No
4. My commute to work takes too much time Yes No
5. I do not have enough friends/neighbors Yes No
6. My neighbors don't like me..... Yes No
7. It is a dangerous neighborhood in which to live Yes No
8. Having so many household tasks irritates me Yes No
9. The weather here bothers me Yes No
10. I'm new to this area Yes No
11. Other neighborhood problems Yes No

If yes, describe:

FAMILY STRESSES

12. I am recently married Yes No
13. I am recently divorced or separated Yes No
14. I am recently moved or am planning to move Yes No
15. I am alone too much at home Yes No
16. My partner and I work different watches Yes No
17. I am concerned about my relationship with my partner Yes No

18. I am concerned about my relationship with another family member
(Parent, child, brother, sister) Yes No
19. I feel I was raised in a dysfunctional environment Yes No
20. There is a new baby in the family Yes No
21. I or one of my family members is having legal problems Yes No
22. There was a recent death of a family member or close friend Yes No
23. There is a serious illness in my family Yes No
24. I sustained an injury on duty that impacts my home life Yes No
25. I am worried about one of my family members Yes No
26. Someone close to me drinks too much Yes No
27. One of my children has moved away from home recently Yes No
28. Someone in my family is engaged in behavior that could put me at risk
on the job Yes No
29. My partner has recently retired Yes No
30. Other concerns about home Yes No
-
-
-

WORK STRESSES

31. I am bored with the work I do Yes No
32. Other people make too many demands on me Yes No
33. I have too little control over my own work Yes No
34. I am not satisfied with the work that I do Yes No
35. Often I feel overwhelmed by my responsibilities Yes No
36. There is not enough time to finish my work Yes No
37. I just began a new job Yes No
38. I just lost my job Yes No
39. I feel burned out at work Yes No
40. The public doesn't appreciate or understand the work we do Yes No
41. I stopped watching or reading the news because of the job..... Yes No
42. I have a department complaint pending..... Yes No
43. I have been demoted. Yes No
44. I feel betrayed by my department/agency.. Yes No
45. The Department doesn't care about its employees. Yes No

- 46. I no longer feel "safe" at work Yes No
 - 47. On the job you're "guilty" until proven "innocent" Yes No
 - 48. I don't get along with my boss/employees Yes No
 - 49. I am having problems with people I work with Yes No
 - 50. I am the target of retaliation Yes No
 - 51. I hate the media portrayals of (LEO, 911, etc.) Yes No
 - 52. Other work-related concerns Yes No
- Describe _____

PERSONAL STRESSES

- 53. I worry about money a great deal Yes No
- 54. I feel lonely Yes No
- 55. I'm involved in "things" outside of work that I feel unable to get out of Yes No
- 56. I am bored with my life Yes No
- 57. I am generally concerned about my health Yes No
- 58. I think a lot about dying Yes No
- 59. I have particular concerns related to my religion Yes No
- 60. Other personal concerns (describe)

STRESS EFFECTS

- 61. I have difficulty falling asleep Yes No
- 62. I have difficulty staying awake Yes No
- 63. I have difficulty staying asleep Yes No
- 64. I feel tired when I wake up in the morning Yes No
- 66. I have nightmares Yes No
- 67. I feel nervous most of the time Yes No
- 68. I often feel depressed Yes No
- 69. I worry a lot Yes No
- 70. I am ill frequently Yes No
- 71. I have some sexual problems..... Yes No
- 72. I have no interest in sex anymore Yes No
- 73. My sexual interests/preferences have changed since I've been on the job Yes No
- 74. I can't stop thinking about sex.. Yes No

- 75. My partner complains that I've changed Yes No
- 76. I have considered committing suicide Yes No
- 77. I sometimes feel weak or light headed Yes No
- 78. I often have pains in my shoulders, neck or back Yes No
- 79. I often feel like crying Yes No
- 80. I'm not comfortable in public places anymore Yes No
- 81. I don't go out unless I'm armed Yes No
- 82. I have trouble letting my own kids be kids since coming on the job..... Yes No
- 83. I drink too much coffee Yes No
- 84. I smoke too much Yes No
- 85. I often drink too much alcohol Yes No
- 86. I eat more than I used to Yes No
- 87. I eat much less than I used to Yes No
- 88. I am concerned about my weight Yes No
- 89. Nothing about my body is perfect Yes No
- 90. I lose my temper more than I used to Yes No
- 91. I don't care what happens to me anymore Yes No
- 92. Sometimes I'm afraid of losing control and not being able to stop..... Yes No
- 93. I don't trust anyone anymore Yes No
- 94. I have affairs when I know I shouldn't Yes No
- 95. I can't stop thinking about what happened (describe) _____

- 96. I think I can be helped by counseling Yes No
- 97. Other concerns Yes No

Describe

104. Has your family background or personal history added in any significant way to your experience professionally? Yes No

How?

105. Is there anything about you personally that you believe has become an advantage for you in your profession?

106. Have you changed since taking this job? Yes No

In what way?

107. Is this change OK with you? Yes No

108. Would others who know you well agree with you? Yes No

109. What would they say?

116. Any recommendations to anyone else on the job?

Last, please circle the answers to any statements or concerns that bother you a great deal.

Thank you.

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