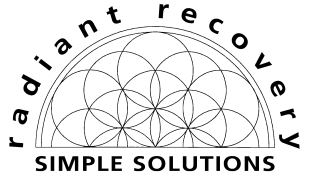

You are making a huge commitment to your healing and I am committed to help you in whatever ways I can. I am including a fairly extensive assessment package. By filling this out before hand, we can maximize our time together. I am really looking forward to our telephone conversation.

Here is what is included:

1) An Appointment verification

2) An Assessment Questionnaire

3) Some questions about how you are

4) A Symptoms questionnaire

5) A MAST test (if you do not drink, don't fill out. If you have had a problem with alcohol and no longer drink, fill this out for when you drank the most.

6) A food plan questionnaire.

If you are sending the file back by email, simply work in it WORD and put your answers in bold. It will be quite clear to me what they are. If there is anything else that comes up for you, please let me know.

Kathleen

radiant recovery
SIMPLE SOLUTIONS

Thank You For Your Interest in Our Services.

Name: _____ Phone: _____

Your first session will be held at:

BY TELEPHONE at this 505-345-3737 on

Cost: Your session will be $200 for a one-hour session. You may pay with cash, check or VISA at the time of service. Payment for telephone appointments must be received at least 48 hours prior to the appointment time. Payments should be sent to

3805 Manchester Drive, Albuquerque, NM 87107

Please Note: Unless you cancel 48 hours in advance, you will be charged for a missed session,

Please fill out this assessment prior to our telephone consultation. Do a food journal for at least one week. It does not have to be done well or in a complete manner, but it is an essential diagnostic tool for us to use together. Think through any questions you might have. Write them down before we talk. This is your time. I am in service to your healing. The clearer you are about what you would like from me, the more fruitful our time can be.

❑ FAX the above information to 505-345-3057

If you have any questions, please call the office at 1-505-345-3737 or email me at radiantkd@mindspring.com

Name:	Date:
Address:	Date of Birth:
City, State, Zip:	Race/Ethnicity:
Telephone:	

What is your specific interest in our program?
How did you hear about us?

****All information will be held in strict confidence.**
Please skip any question that does not apply.

Physical History:		
Do you have any medical conditions that could affect how you feel?	Yes	No
Can you tell us about them?		
Height Weight		
Do you feel overweight?	Yes	No
Was either of your parents overweight?	Mother	Father
Is it hard for you to lose weight?	Yes	No
Are you afraid of gaining weight?	Yes	No
Have you ever dieted?	Yes	No
Outline your diet history.		
What are your favorite foods? (Please list.)		

Sugar:		
Are you fond of sugar?	Yes	No
On a scale of 1 to 10 (10 is Yes!!), rate your fondness.	1 2 3 4 5 6 7 8 9 10	
Are/were either of your parents especially fond of sugar?	Mother	Father
Are you fond of breads, pasta or popcorn?	Yes	No
On a scale of 1 to 10 (10 is Yes!!), rate your fondness.	1 2 3 4 5 6 7 8 9 10	
Are/were either of your parents especially fond of breads, pasta or popcorn?	Mother	Father
Do you eat regular meals?	Yes	No
Do you "graze"?	Yes	No

Addiction History:		
Have you ever had a problem with alcohol and/or drugs?	Yes	No
What was/is your drug of choice?		
Do you use alcohol and/or drugs now?	Yes	No
Did either of your parents have a problem with alcohol and/or drugs?	Mother	Father
Do you feel you are addicted to sugar?	Yes	No
Do you feel you are addicted to white flour products?	Yes	No
Are you, or have you ever been, in any 12-step programs? (Please indicate which ones.)	Yes	No

Mental Status:		
Do you feel you are depressed?	Yes	No
Do you take anti-depressant medication?	Yes	No
Which?	Dosage?	
Do you feel you overreact to stress?	Yes	No
Do you have a violent temper?	Yes	No
Do you have outbursts of rage?	Yes	No
Are you taking any psychiatric medication?	Yes	No
Which?	Dosage?	

Please use this space if you wish to give us any additional information about the questions asked on the previous pages.
Do you have any questions you would like us to answer?

Please circle the number that best describes you											
	Never				Sometimes					Always	
1. I am tired all the time	1	2	3	4	5	6	7	8	9	10	1.
2. I get tired for no reason	1	2	3	4	5	6	7	8	9	10	2.
3. I am restless and can't keep still	1	2	3	4	5	6	7	8	9	10	3.
4. I get confused	1	2	3	4	5	6	7	8	9	10	4.
5. I have trouble remembering things clearly	1	2	3	4	5	6	7	8	9	10	5.
6. I get frustrated	1	2	3	4	5	6	7	8	9	10	6.
7. I am more irritable than usual	1	2	3	4	5	6	7	8	9	10	7.
8. I get angry unexpectedly	1	2	3	4	5	6	7	8	9	10	8.
9. I have a hard time concentrating	1	2	3	4	5	6	7	8	9	10	9.
10. I have trouble sleeping	1	2	3	4	5	6	7	8	9	10	10.
11. I am concerned about my weight	1	2	3	4	5	6	7	8	9	10	11.
12. I have a hard time losing weight	1	2	3	4	5	6	7	8	9	10	12.
As a Child I had . . .											
13. Earaches	1	2	3	4	5	6	7	8	9	10	13.
14. Colic	1	2	3	4	5	6	7	8	9	10	14.
15. Frequent colds	1	2	3	4	5	6	7	8	9	10	15.
16. Frequent coughs	1	2	3	4	5	6	7	8	9	10	16.
17. Asthma	1	2	3	4	5	6	7	8	9	10	17.
18. Eczema	1	2	3	4	5	6	7	8	9	10	18.
19. Allergies	1	2	3	4	5	6	7	8	9	10	19.
20. Dark circles under my eyes	1	2	3	4	5	6	7	8	9	10	20.
As an adult I have . . .											
21. Frequent colds	1	2	3	4	5	6	7	8	9	10	21.
22. Headaches	1	2	3	4	5	6	7	8	9	10	22.
23. Stomach pain	1	2	3	4	5	6	7	8	9	10	23.
24. Low back pain	1	2	3	4	5	6	7	8	9	10	24.
25. Shoulder/muscle pain	1	2	3	4	5	6	7	8	9	10	25.
26. Shakiness	1	2	3	4	5	6	7	8	9	10	26.
27. PMS	1	2	3	4	5	6	7	8	9	10	27.
29. Low sexual responsiveness	1	2	3	4	5	6	7	8	9	10	29.
30. Dizziness	1	2	3	4	5	6	7	8	9	10	30.
31. Itching eyes	1	2	3	4	5	6	7	8	9	10	31.
32. Ringing in my ears	1	2	3	4	5	6	7	8	9	10	32.
33. Fast heart beat	1	2	3	4	5	6	7	8	9	10	33.

Michigan Alcoholism Screening Test (MAST)

Name:			Date:		
	Yes	No		Yes	No
2 **1.** Do you feel you are an abnormal drinker?	o	o	5 **20**. Have you ever gone to anyone fo help about your drinking?	o	o
2 **2**. Have you ever awakened the morning after some drinking the night before that you could not remember a part of the evening before?	o	o	5 **21.** Have you ever been in a hospital because of drinking?	o	o
1 **3.** Does your spouse (or parent) ever worry or complain about your drinking?	o	o	2 **22**. Have you ever been a patient in a psychiatric hospital or in a psychiatri ward of a general hospital where drinking was part of the problem?	o	o
2 **4.** If you stop drinking after one or two drinks is there a struggle? Do you really want more?	o	o	2 **23.** Have you ever been seen at a psychiatric or mental health clinic, or gone to a doctor, social worker, or clergyman for help with an emotiona problem in which drinking played a part?	o	o
1 **5**. Do you ever feel bad about your drinking?	o	o	2 **24**. Have you ever been arrested, even for a few hours, because of drunken behavior?	o	o
2 **6.** Do your friends and relatives think you are an abnormal drinker?	o	o	2 **25.** Have you ever been arrested for drunk driving or driving after drinking?	o	o
0 **7.** Do you ever try to limit your drinking to certain times of the day or to certain places?	o	o	SCORE POINTS AS INDICATED FOR ALL YES ANSWERS		
2 **8.** Are you unable to stop drinking when you want to?	o	o	**TOTAL**		
5 **9.** Have you ever attended a meeting of AA (Alcoholics Anonymous)?	o	o			
1 **10.** Have you ever gotten into fights when drinking?	o	o			
2 **11.** Has drinking ever created problems with you and your spouse?	o	o			
2 **12.** Has your spouse (or another family member) ever gone to anyone for help about your drinking?	o	o			
2 **13**. Have you ever lost any friends or girl friends/boy friends because of your drinking?	o	o			
2 **14.** Have you ever gotten into trouble at work because of drinking?	o	o	1 **1.** Have you ever felt you should cut down on your drinking?	o	o
2 **15.** Have you ever lost a job because of drinking?	o	o	1 **2.** Have people ever annoyed you by criticizing your drinking?	o	o

2 **16.** Have you ever neglected your obligations, your family or your work for 2 or more days in a row because you were drinking?	o	o	1 **3.** Have you ever felt bad or guilty about your drinking?	o	o
1 **17**. Do you drink before noon?	o	o	1 **4.** Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (a "eye-opener")?	o	o
2 **18**. Have you ever had delirium tremens (D.T.'s), severe shaking, heard voices or seen things that weren't there after heavy drinking?	o	o	SCORE POINTS AS INDICATED FOR ALL YES ANSWERS		
2 **19.** Have you ever been told you have a liver problem?	o	o	**TOTAL**		

Food Plan Questionnaire

Name:	Date:	
	Yes	No
1. I use alcohol	o 0	o 1
2. I eat three times a day at regular intervals	o 1	o 0
3. I eat protein at each meal	o 1	o 0
4. I eat approximately the recommended amount of protein each day (.4 grams x my weight)	o 1	o 0
5. I use caffeine in coffee o tea o cola o Indicate how much you drink in a day	o 0	o 1
6. I use overt sugar (table sugar, cake, cookies, ice cream, candy, etc.)	o 0	o 1
7. I use covert sugar (such as high fructose corn syrup hidden in food)	o 0	o 1
8. I use refined white flour products such as bread and pasta	o 0	o 1
9. I smoke cigarettes (_____per day)	o 0	o 1
10. I take the vitamins as recommended by the program	o 1	o 0
	TOTAL	