Initial Appointment Questionnaire

Thank you scheduling this appointment. I am looking forward to meeting with you. Your responses to this questionnaire will help me to more quickly understand your concerns and how I can help you to reach your health and wellness goals.

David Alter, PhD

General Information:

Name:

Age / Date of Birth:

Mailing Address:

Home Phone / Work Phone / Cell Phone:

E-mail Address:

Present Situation:

What are the main concerns prompting you to seek help at this time?

What are your primary goals for this appointment?

What are the major symptoms or difficulties that you want to address in your treatment?

If you could change one thing that would have a positive impact on your life, what would that be?

What are the current ways you have found to manage the stress in your life (hobbies, exercise, reading, etc.)?

Physical Health History:

Are you being treated currently for any medical concern(s)? If so, please describe the concern(s).

Please describe any past surgeries, hospitalizations, illnesses or major injuries you have experienced in the past (please indicate approximately when these experiences occurred)?

Please list any prescribed medications that you are currently using, or any herbal, homeopathic or nutritional supplements that you use on a regular basis?

Family System Information:

What is your current relationship status?

- ◯ Single
- ◯ Married/Partnered
- ◯ Separated/Divorced
- ◯ Spouse/Partner Deceased
- ◯ Other

If you are married, is this your first marriage?

- ◯ Yes
- ◯ No
- ◯ How many previous marriages?

If you have children, please provide their names and ages.

Where are you currently living and with whom do you live?

Family History & Self-Identity:

Please describe details of your family of origin (parents, siblings, divorces, adoptions, etc.).

Please describe the emotional atmosphere in the household in which you were raised (e.g., calm, loving, chaotic, abusive, violent, unpredictable, etc.).

How would you describe your self-concept (i.e., your view of who you are) or self-esteem (i.e., your feelings and beliefs about yourself)?

What experience(s) stand out in your mind as something of which you are proud?

What experience(s) stand out in your mind as something about which you feel guilty or ashamed?

Did you ever experience physical, sexual, emotional and/or verbal abuse in your past? If so, please indicate when and what relationship, if any, the perpetrator of the abuse had to you.

Occupational/Educational History:

Please describe your current occupation. If not currently employed, please describe what work you did when last employed.

Please describe past occupations (what was your job, how long did you work in previous jobs, why you left previous jobs, etc.).

What is the highest level of education that you completed?

- ◯ High school
- ◯ Trade School
- ◯ Post-High School Certificate
- ◯ AA Degree
- ◯ Four-year College Degree
- ◯ Post-graduate Degree
- ◯ Other

Do you have a history of learning difficulties that have interfered with job performance? If so, please describe them. Did you ever receive special educational assistance?

Legal Concerns:

Do you have a history of any legal difficulties (e.g., DUI arrest, domestic violence charge, other legal conflicts)? Please describe them and approximately when they occurred.

Have you ever been sentenced to prison? If so, for what offense, and for how long?

- [ ] No
- [ ] Yes

What was the offense for which you were sentenced?

For how long were you incarcerated?

Knowing Your Mind and Body Stress Signals

The next section of the questionnaire asks about symptoms or concerns you may be experiencing in a number of different areas of your life. Please review each different area listed and check those items that represent what you are currently experiencing.

Physical Symptoms:

- ☐ Headaches
- ☐ Indigestion
- ☐ Stomachaches
- ☐ Sweaty palms
- ☐ Sleep problems
- ☐ Dizziness
- ☐ Back pain
- ☐ Muscle tightness
- ☐ Racing heart
- ☐ Restlessness
- ☐ Tiredness
- ☐ Chronic fatigue
- ☐ Fainting spells
- ☐ Seizures
- ☐ Chest pain
- ☐ Rapid heart beat
- ☐ Blackouts
- ☐ Rapid breathing
- ☐ Visual problems
- ☐ Hearing problem
- ☐ Sexual problems
- ☐ Shift in sex drive
- ☐ Agitation
- ☐ Excessive sweats
- ☐ Weight change
- ☐ Bowel changes
- ☐ Numbness
- ☐ Body pains

Relationship Concerns:

- ☐ Isolation
- ☐ Intolerance
- ☐ Resentment
- ☐ Loneliness
- ☐ Lashing out
- ☐ Clamming up
- ☐ Low Sex Drive
- ☐ Nagging
- ☐ Distrust
- ☐ Lack of intimacy
- ☐ Manipulation
- ☐ Withdrawal
- ☐ Abuse
- ☐ Coworker problems
- ☐ Family conflicts
- ☐ Spouse conflict
- ☐ Conflict with friends
- ☐ Hard forming relationships
- ☐ Find that others take advantage of you
- ☐ Hard to express feelings to others
- ☐ Find you are too dependent on others
- ☐ Work too hard to please others
- ☐ Fear disappointing others
- ☐ Relationship can't seem to last
- ☐ Can't commit to relationship(s)
- ☐ Engage in sexual behavior that don't like

Behavioral Concerns:

- ☐ Excessive smoking
- ☐ Hyper-criticalness
- ☐ Compulsive behaviors
- ☐ Overusing alcohol
- ☐ Overusing caffeine
- ☐ Drug use
- ☐ Compulsive eating
- ☐ Procrastination
- ☐ Disorganization
- ☐ Other _____

Cognitive Concerns:

- [ ] Clouded thinking
- [ ] Memory loss
- [ ] Forgetfulness
- [ ] Indecisiveness
- [ ] Constant worry
- [ ] Confusion
- [ ] Intrusive thoughts
- [ ] Slowed thinking
- [ ] Inattentive
- [ ] Poor concentration
- [ ] Other

Emotional Concerns:

- [ ] Frequent Crying
- [ ] Lack of meaning
- [ ] Feel powerless
- [ ] Feel helpless
- [ ] Feel explosive
- [ ] High anxiety/panic
- [ ] Unhappy without reason
- [ ] Aimless
- [ ] Easily irritated
- [ ] Impatient
- [ ] Often angry
- [ ] Unforgiving
- [ ] Excessive self-sacrificing
- [ ] Excessive cynicism
- [ ] Apathy
- [ ] Loss of life direction
- [ ] Loss of life purpose
- [ ] Chronic guilt/shame
- [ ] Other

Patterns of Chemical Use

Please indicate any mood altering substances you use. Please describe your pattern of use in more detail below.

- [ ] Wine
- [ ] Beer
- [ ] Liquor
- [ ] Marijuana
- [ ] Barbiturates
- [ ] Stimulants
- [ ] Tranquilizers
- [ ] Hallucinogens
- [ ] Inhalants
- [ ] Narcotics
- [ ] Tobacco
- [ ] Other

Please describe you current pattern of alcohol use (amount & frequency)

Do you use cigarettes or other nicotine-containing products, how often and how long have you used them?

If you use "street" drugs, please describe the substance(s) and your pattern of use

Has your use of alcohol or "street" drugs resulted in:

- [ ] Legal consequences (e.g., DUI)
- [ ] Work consequences (e.g., job loss)
- [ ] Conflict in personal relationships
- [ ] Substance abuse treatment?

Have you ever participated in chemical dependency treatment? Please describe what you were treated for and your experience of the treatment process?

How did you learn about **Dr. Alter** or **Partners in Healing**?

☐ From a friend/acquaintance ☐ From a health professional

☐ From the Internet

☐ Please provide health professional's name:

Thank you for taking the time to complete this questionnaire. I will review it prior to meeting with you if you fax it (**763-546-5754**) or mail it to me (**10505 Wayzata Boulevard, Suite 200, Minnetonka, MN 55305**). Otherwise, I will review it during our initial meeting.

Please call **Partners in Healing** at **763-546-5797** if you need to reschedule or cancel your appointment.

It is expected that you provide **Dr. Alter** with 24-hour advance notice if you are unable to keep the scheduled appointment. Failure to provide **Dr. Alter** or **Partners in Healing** with 24-hour notice of the need to cancel a scheduled appointment may result in you being billed for the missed appointment.