

# Wellness Assessment

Client Name: \_\_\_\_\_ Date: \_\_\_\_\_

Thank you for completing this brief questionnaire. It will help me provide services that meet your needs.

## Health & Social Information:

Primary Care Physician: \_\_\_\_\_

Psychiatrist: \_\_\_\_\_

Are you currently taking prescribed medications?  Yes  No

Please list: \_\_\_\_\_

How is your physical health at present? (circle one)

Unsatisfactory      Satisfactory      Good      Very Good

Please list any persistent physical symptoms or health concerns you may have.

Are you having any problems with your sleep habits?  Yes  No

Sleeping too little     Sleeping too much     Poor quality sleep

Are you having difficulty with your appetite or eating habits?  Yes  No

Have you experienced weight change in the last 2 months?  Yes  No

How often do you drink alcohol?  Never  Rarely  Monthly  Weekly  Daily

In a typical month, how often do you have four or more drinks in a 24-hour period?

How often do you engage in recreational drug use?

Daily  Weekly  Monthly  Rarely  Never

In the past few months, have you felt annoyed with people for criticizing your drinking or drug use?  Yes  No

In the past year, have you experienced any significant life changes, losses, or stressors?

(List) \_\_\_\_\_

## Have you experienced? (please check all that apply)

Depressed mood

Phobias

Mood swings

Aches and pains

Rapid speech

Eating disorder

Anxiety

Hallucinations

Panic attacks

Unexplained loss of time or memory

Cutting

Suicidal attempt(s)  Number

Do you have supportive friends or family members?  Yes  No

What are your greatest strengths? Assets? What do you like about your self?

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