

What symptoms are related to this problem? Please check **all** that apply for you **now**:

- | | | | |
|---|---------------------------|---|-------------------------------|
| <input type="checkbox"/> Y <input type="checkbox"/> N | Depressed Mood | <input type="checkbox"/> Y <input type="checkbox"/> N | Overeating |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Crying | <input type="checkbox"/> Y <input type="checkbox"/> N | Recent weight loss |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Low motivation | <input type="checkbox"/> Y <input type="checkbox"/> N | Recent weight gain |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Difficulty concentrating | <input type="checkbox"/> Y <input type="checkbox"/> N | Dizziness/lightheadedness |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Easily distracted | <input type="checkbox"/> Y <input type="checkbox"/> N | Trembling or shaking |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Social withdrawal | <input type="checkbox"/> Y <input type="checkbox"/> N | Sweating |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Feelings of worthlessness | <input type="checkbox"/> Y <input type="checkbox"/> N | Chest pain |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Restlessness | <input type="checkbox"/> Y <input type="checkbox"/> N | Rapid heart rate |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Anxiety | <input type="checkbox"/> Y <input type="checkbox"/> N | Shortness of breath |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Fears/phobias | <input type="checkbox"/> Y <input type="checkbox"/> N | Stomach problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Startle easily | <input type="checkbox"/> Y <input type="checkbox"/> N | Vomiting |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Obsessions | <input type="checkbox"/> Y <input type="checkbox"/> N | Muscle tension |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Compulsive behaviors | <input type="checkbox"/> Y <input type="checkbox"/> N | Pain |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Odd behavior/thoughts | <input type="checkbox"/> Y <input type="checkbox"/> N | Sexual difficulties |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Aggressive behavior | <input type="checkbox"/> Y <input type="checkbox"/> N | Family emotional problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Outbursts of temper | <input type="checkbox"/> Y <input type="checkbox"/> N | Problems with work/school |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Distrust/Paranoia | <input type="checkbox"/> Y <input type="checkbox"/> N | Housing problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Fatigue/loss of energy | <input type="checkbox"/> Y <input type="checkbox"/> N | Relationship problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Sleeping too much | <input type="checkbox"/> Y <input type="checkbox"/> N | Financial problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Decreased need for sleep | <input type="checkbox"/> Y <input type="checkbox"/> N | Drinking alcohol |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Difficulty falling asleep | <input type="checkbox"/> Y <input type="checkbox"/> N | Taking drugs |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Difficulty staying asleep | <input type="checkbox"/> Y <input type="checkbox"/> N | Experienced a traumatic event |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Nightmares | <input type="checkbox"/> Y <input type="checkbox"/> N | Other: _____ |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Recent appetite change | | _____ |

If applicable, please describe any incidents or problems that may have contributed to this problem (e.g., problem with work or school, relationship ending, past trauma, etc.):

In the past, what has been helpful to you in dealing with this problem?

SECTION III: MEDICAL HISTORY

Name of physician: _____ Date of last physical exam: _____
 Address: _____ City: _____ State: _____ Zip Code: _____

Please list any significant past or current **health, medical, or psychiatric issues** (including anything resulting in hospitalizations).

Dates	Problem	Treatment	Were you hospitalized (Y/N)

Have you **ever had treatment by**, or are you **currently seeing**, a psychiatrist, psychologist, therapist, or counselor?
 Y N

Problem	Therapist	When	Helpful (Y/N)

Have you ever been given a mental health diagnosis in the past from a mental health professional? Y N
 If yes, what is/was that diagnosis? _____

SECTION IV: MEDICATIONS AND SUBSTANCES USED

If applicable, please list all medications you are now taking or have taken in the past three months, including birth control pills, vitamins, herbs and supplements.

Medication	Dosage/Frequency	Person Prescribing	How long have you been taking this?	Helpful (Y/N)

How many **caffeinated** beverages do you drink per day: coffee _____ soda _____ espresso _____ tea _____
 Do you use tobacco? Y N If yes, what types and how much do you use per day? _____

Do you use marijuana? Y N If yes, how often? _____

Consider a typical week during the **past month**. Please fill in a number for each day of the week indicating the typical number of drinks you usually consume on that day and the typical number of hours you usually drink on that day.

1 Drink = 12 oz. beer, 4 oz. wine, 1 oz. hard liquor (regular shot glass)

	Su	M	Tu	W	Th	F	Sa
Drinks							
Hours							

Think of the occasion that you drank the most in the **past month**.

How much did you drink? _____ How many hours did you drink? _____

Do you use any other drugs or substances? Y N

If yes, list the substances used: _____

Do you use alcohol or drugs to (check all that apply):

- Manage stress?
- To relax?
- To change your mood?
- For sleep?

SECTION V: FAMILY OF ORIGIN INFORMATION

	Age	Name	Occupation	Deceased (Y/N)
Parent/Guardian	___	_____	_____	___
Parent/Guardian	___	_____	_____	___
If applicable:				
Stepparent	___	_____	_____	___
Stepparent	___	_____	_____	___
Siblings	___	_____	_____	___
	___	_____	_____	___
	___	_____	_____	___
Child <input type="checkbox"/> M <input type="checkbox"/> F	___	_____	_____	___
Child <input type="checkbox"/> M <input type="checkbox"/> F	___	_____	_____	___
Child <input type="checkbox"/> M <input type="checkbox"/> F	___	_____	_____	___
Child <input type="checkbox"/> M <input type="checkbox"/> F	___	_____	_____	___

Are your parents divorced? Y N

Have any members of your family had problems with:

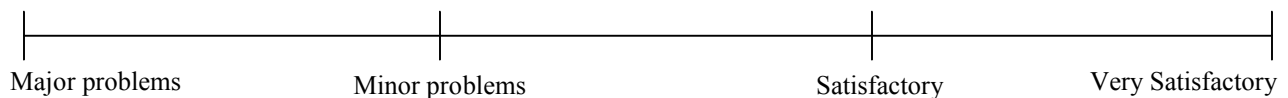
- drugs alcohol depression anxiety other mental illness diabetes epilepsy

Problem	Who?	Current (Y/N)	Past (Y/N)

Among your friends and family, on whom do you count for support? _____

Are you: Single Dating Married / Partnered Divorced /Unpartnered Widowed /Surviving partner

If applicable, describe your relationship with your current partner (place an X on the line below).



How long have you been in the relationship? _____

How did you hear about The Wellness Point? _____