

Wellness Assessment - Adult

Completing this brief questionnaire will help us provide services that meet your needs. Answer each question as best you can and then review your responses with your clinician. Please shade circles like this ●

Client Last Name: **S M I T H** , First Name: **J A N E** , Date of Birth: (mm/dd/yy) **01 / 01 / 56**

Subscriber ID: **9 8 7 6 5 4 3 2 1** , Authorization #: **A 1 B 2 3 C - 0 1**

Clinician Last Name: **J O H N S O N** , First Name: **J O H N** , Today's Date: (mm/dd/yy) **05 / 31 / 07**

Clinician ID/Tax ID: **8 2 0 0 0 1 1 0 0** , Clinician Phone: **8 0 0 5 5 5 - 4 5 5 6** , State: **M O** , MRef

Visit #: 1 or 2 3 to 5 Other

For questions 1-16, please think about your experience in the past week.

How much did the following problems bother you?	Not at All	A Little	Somewhat	A Lot
1. Nervousness or shakiness	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Feeling sad or blue	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
3. Feeling hopeless about the future	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
4. Feeling everything is an effort	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
5. Feeling no interest in things	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
6. Your heart pounding or racing	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. Trouble sleeping	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
8. Feeling fearful or afraid	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. Difficulty at home	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. Difficulty socially	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. Difficulty at work or school	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>

How much do you agree with the following?	Strongly Agree	Agree	Disagree	Strongly Disagree
12. I feel good about myself	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
13. I can deal with my problems	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
14. I am able to accomplish the things I want	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>
15. I have friends or family that I can count on for help	<input type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
16. In the past week, approximately how many drinks of alcohol did you have?				<input type="text" value="1"/> Drinks

- Please answer the following questions only if this is your first time completing this questionnaire.**
17. In general, would you say your health is: Excellent Very Good Good Fair Poor
18. Please indicate if you have a serious or chronic medical condition:
 Asthma Diabetes Heart Disease Back Pain or Other Chronic Pain Other Condition
19. In the past 6 months, how many times did you visit a medical doctor? None 1 2-3 4-5 6+
20. In the past month, how many days were you unable to work because of your physical or mental health? Days
(answer only if employed)
21. In the past month, how many days were you able to work but had to cut back on how much you got done because of your physical or mental health? Days
(answer only if employed)
22. In the past month have you ever felt you ought to cut down on your drinking or drug use? Yes No
23. In the past month have you ever felt annoyed by people criticizing your drinking or drug use? Yes No
24. In the past month have you felt bad or guilty about your drinking or drug use? Yes No