Pre-Treatment Wellness Self-Assessment

Name: ____ Today's Date: _____/_____/______

List up to three concerns that you would like help with in therapy, and use the following scale to rate the level of each of these concerns

Your Concern	Not a problem	Mild Problem	Moderate problem	Severe Problem	Couldn't be worse
1.					
2.					
3.					

In the past month, how much have the following problems bother you?	***1 Not a problem***	***2 Mild Problem***	***3 Moderate Problem***	***4 Severe Problem***	***5 Couldn't be worse***
1. Nervousness or shakiness?					
2. Feeling sad or blue?					
3. Feeling hopeless about the future?					
4. Feeling everything is an effort?					
5. Feeling no interest in things?					
6. Your heart pounding or racing?					
7. Trouble sleeping?					
8. Feeling fearful or afraid?					
9. Difficulty at home?					
10. Difficulty socially?					
11. Difficulty at work or school?					

How much do you agree with the following?	***1 Completely Agree***	***2***	***3 Somewhat Agree***	***4***	***5 Do Not Agree***
12. I feel good about myself.					
13. I can deal with my problems.					
14. I am able to accomplish the things I want.					
15. I have friends or family that I can count on for help.					
16. My health is good.					
17. I have not needed to visit a doctor for a physical or mental health concern in the past month.					
18. My overall health is good enough that I can go to work.					
19. My overall health is good enough that I can be productive at work.					

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Family Members in Household

Name	*Age*	*Relationship to You*

Have you ever received other mental health treatment? If yes, please fill in the following chart.

Received Services?	*Type of Treatment*	*Year(s) Received*
	Therapy	
	Outpatient Therapy	
	Inpatient Hospitalization	
	Partial Hospitalization	
	Peer Support	

Indicate "yes" or "no" for the following questions

	Yes	**No**
In the past month, did you think that you would be better off dead or wish you were dead?		
Have you ever felt so hopeless that you wished you could die?		
Have you ever felt you ought to cut down on your drinking or drug use?		
Have you ever felt annoyed by people criticizing your drinking or drug use?		
Have you felt bad or guilty about your drinking or drug use?		
Have you ever felt unsafe or afraid at home?		
Have you ever felt threatened by someone who you love or care about?		
Have you ever felt controlled by another person at home?		
Have you had any legal issues in the past 6 months?		
Have you had any significant financial issues in the past 6 months?		

Do you have any other legal or financial issues of note that you would like to tell us about?

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