Family Therapy Clinic

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Wellness Checklist

Recent Symptoms: Indicate any symptoms experienced in the past 1-2 weeks**.**

□ Daytime Fatigue / Sedation	□ Habitual / Compulsive Behavior
□ Sadness	□ Fears / Phobias
□ Crying Spells / Tearfulness	□ Social Anxiety
□ Irritability	□ Traumatic Event (w/in last year)
□ Anger	□ Eating Disorder (past or present)
□ Difficulty Concentrating	□ Sleep Disturbance (_____hrs/night)
□ Feeling Overwhelmed	□ Nightmares / Bad Dreams
□ Feeling Hopeless	□ Trouble Falling Asleep
□ Apathy / Loss of Interest in Previously Enjoyed Activities	□ Trouble Staying Asleep
	□ Appetite Increase
□ Isolating / Avoiding People	□ Appetite Decrease
□ Suicidal Thoughts	□ Weight Change Past Month (_____lbs)
□ Worry / Anxiety	□ Other_____
□ Panic Attacks	

Tobacco Use: □ No tobacco use

Amount per day_____ Recent increase: □ Yes □ No

Alcohol Use: □ No alcohol use

Amount per day_____ Recent increase: □ Yes □ No

Substance Use: □ No substance use

Past use_____ (list)

Current use_____ (list)

Recent increase: □ Yes □ No

Females Only: Possibly pregnant? □ Yes □ No *(If Yes, _____ weeks pregnant)*

Use of birth control? □ Yes □ No *(If Yes, list type_____)*

_____ _____

Patient Printed Name ***Date***