Body Mind and Spirit Counseling & Wellness Center, LLC
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New Client
Wellness Checklist

Name *

Date

Please check any symptoms that may apply to you within the last TWO WEEKS *

- ☐ Fatigue
- ☐ Crying spells/ tearfulness
- ☐ Sadness
- ☐ Irritability
- ☐ Anger
- ☐ Easily Frustrated
- ☐ Feeling Overwhelmed
- ☐ Difficulty Concentrating
- ☐ Apathy / Lost of Interest in Activities
- ☐ Feeling Hopeless
- ☐ Isolating / Avoiding people
- ☐ Suicidal Thoughts
- ☐ Worry / Anxiety
- ☐ Panic Attacks
- ☐ Habitual / Compulsive Behavior
- ☐ Fears / Phobias
- ☐ Social Anxiety
- ☐ Traumatic Event (within the last year)
- ☐ Eating Disorder (either past or present)
- ☐ Sleep Disturbance
- ☐ Trouble Falling Asleep
- ☐ Trouble Staying Asleep
- ☐ Appetite - Eating more
- ☐ Appetite - Eating less
- ☐ Others _____

How many hours of sleep do you get each night? *

Have you experiences any nightmares/bad dreams? ☐ Yes ☐ No

Have you had any weight change in the last month? If so, how much?

Alcohol Use

Amount used per week

Has your use increased recently? ☐ Yes ☐ No

Tobacco Use

Amount used per day

Has your use increased recently? ☐ Yes ☐ No

Substance Use

Substance use ☐ Past ☐ Present ☐ Never

Has your use increased recently? ☐ Yes ☐ No