Name:_____ Date:_____

Intake Client Wellness Self-Report

For each item, CIRCLE the answer that matches your view:	**Strongly Agree**	**Agree**	**Neutral**	**Disagree**	**Strongly Disagree**	**Not Appropriate**
I deal well with my daily problems.	5	4	3	2	1	0
I deal well with crisis.	5	4	3	2	1	0
I get along well with my family.	5	4	3	2	1	0
I do well in social situations.	5	4	3	2	1	0
I do well in school and/or work.	5	4	3	2	1	0
I feel calm.	5	4	3	2	1	0
I feel hopeful.	5	4	3	2	1	0
I feel energy for daily activities and life events.	5	4	3	2	1	0
I have an interest in things.	5	4	3	2	1	0
I sleep well.	5	4	3	2	1	0
My drinking does not cause problems in my life.	5	4	3	2	1	0

In general, would you say your health is Excellent Very Good Good Fair Poor

Please indicate if you have a serious or chronic medical condition.

Asthma Diabetes Heart Disease Back Pain or other Chronic Pain Other Condition

In the past 6 months, how many times did you visit a medical doctor? None 1 2-3 4-5 6+

In the past month, how many days were you unable to work because of your physical or mental health? (answer only if employed) _____

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? (answer only if employed) _____

In the past month have you ever felt you ought to cut down on your drinking or drug use? Yes No

In the past month have you ever felt annoyed by people criticizing your drinking or drug use? Yes No

In the past month, have you felt bad or guilty about your drinking or drug use? Yes No

In the past week how many drinks did you consume?_____