Columbia County
Mental Health Center

Wellness Questionnaire

Today's Date:___________________

Client's First & Last Name: ____

Date of Birth:_____________ Age: _________

Referred here by: ____

Why are you seeking treatment? ____

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What are your symptoms *(please check all that applies)*?

_______ anxiety	_______ depressed/sad	______ appetite/weight changes
_______ panic attacks	_______ crying frequently	______ sleep disturbance
_______ hearing voices	_______ hopelessness	______ repetitive behaviors
_______ fear/phobia	_______ racing thoughts	______ irritable/moody
_______ mania	_______ feel "on edge"	______ low energy/fatigue
_______ low self-esteem	_______ poor concentration	______ difficulty making decisions
_______ lack of enjoyment	Other: ______________________	

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When did these symptoms begin?____

____

____

What do you think would help you? ____

____

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Helping Columbia County Residents Find Hope & Healing For Over 50 Years

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