



Enrichment Wellness, LLC

Enrichment Wellness, LLC
839-G Quince Orchard Boulevard
Gaithersburg Maryland 20878
(202) 701-7738
(301) 762-1937 fax

Questionnaire

Client Information

Name: _____

Date of Birth: _____

Address: _____

Home Phone: _____ Mobile Phone: _____

Email: _____

What brings you to counseling at this time? Is there something specific, such as a particular event? Be as detailed as you can.

What are your goals for counseling?

Have you seen a mental health professional before?

Yes / No (circle one)

Specify all medications and supplements you are presently taking and for what reason.

If taking prescription medication, who is your prescribing MD? Please include type of MD, name and phone number.

Who is your primary care physician? Please include type of MD, name and phone number.

Do you drink alcohol?

Yes / No (circle one)

Do you use recreational drugs?

Yes / No (circle one)



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Do you have suicidal thoughts?

Yes / No (circle one)

Have you ever attempted suicide?

Yes / No (circle one)

Yes / No (circle one)

Yes No

Have you ever been hospitalized for a psychiatric issue?

Yes / No (circle one)

Is there a history of mental illness in your family?

Yes / No (circle one)

If you are in a relationship, please describe the nature of the relationship and months or years together.

Describe your current living situation. Do you live alone, with others, with family, etc?

What is your level of education? Highest grade/degree and type of degree.

What is your current occupation? What do you do? How long have you been doing it?

Please check any of the following you have experienced in the past six months

- | | |
|--|---|
| <input type="checkbox"/> Increased appetite | <input type="checkbox"/> Depressed mood |
| <input type="checkbox"/> Decreased appetite | <input type="checkbox"/> Tearful or crying spells |
| <input type="checkbox"/> Trouble concentrating | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Difficulty sleeping Excessive sleep | <input type="checkbox"/> Fear |
| <input type="checkbox"/> Low motivation | <input type="checkbox"/> Hopelessness |
| <input type="checkbox"/> Isolation from others | <input type="checkbox"/> Panic |
| <input type="checkbox"/> Fatigue/low energy | <input type="checkbox"/> Other |
| <input type="checkbox"/> Low self-esteem | |



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Please check any of the following that apply

- | | |
|---|---|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Faintness |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Heart valve problems |
| <input type="checkbox"/> Gastritis or esophagitis | <input type="checkbox"/> Urinary tract problems |
| <input type="checkbox"/> Hormone-related problems | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Head injury | <input type="checkbox"/> Numbness & tingling |
| <input type="checkbox"/> Angina or chest pain | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Irritable bowel | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Chronic pain | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Loss of consciousness | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Bone or joint problems | <input type="checkbox"/> Thyroid issues |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> HIV/AIDS |
| <input type="checkbox"/> Kidney-related issues | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Chronic fatigue | <input type="checkbox"/> Other |
| <input type="checkbox"/> Dizziness | |

What else would you like me to know?

Signature: _____ **Date:** _____