

◆ Wellness Survey ◆

By completing this survey, **you will be helping us** to learn how best to serve the Community!
 It is a wellness screening used to help people notice if they are experiencing any of the following problems:
Stress, Safety issues, Sleep Problems, Anxiety, Depression, Fear and/or Substance Abuse including Smoking.

THIS SURVEY IS NOT DESIGNED TO DIAGNOSE, TREAT OR CURE ANY SPECIFIC MEDICAL OR MENTAL HEALTH PROBLEM. IT IS FOR INFORMATIONAL PURPOSES ONLY.

If you have answered YES to any of the boxes below, you are welcome to call or email Danielle Owen for more information at the IIC: 617-542-7654 Ext 14 or dowen@iicenter.org. Our Community Counseling Services are free and confidential and we would be delighted to chat with you today about any questions or concerns you may have after completing this survey.

Have you or someone you care about experienced any of the following Emotional Symptoms in the last 6 months?:

<input type="radio"/> Apprehension, uneasiness, & dread	<input type="radio"/> Confusion
<input type="radio"/> Impaired concentration or selective attention	<input type="radio"/> Behavioral problems (especially in children and adolescents)
<input type="radio"/> Feeling restless or on edge	<input type="radio"/> Nervousness and jumpiness
<input type="radio"/> Avoidance	<input type="radio"/> Self-consciousness and insecurity
<input type="radio"/> Hyper vigilance or in constant fear of threat	<input type="radio"/> Fear that you are dying or going crazy
<input type="radio"/> Irritability	<input type="radio"/> Strong desire to escape

Have you or someone you care about experienced any of the following Physical Symptoms in the last 6 months?:

<input type="radio"/> Stomach upset or queasiness	<input type="radio"/> Headaches
<input type="radio"/> Heart palpitations or racing heartbeat	<input type="radio"/> Chest pain
<input type="radio"/> Frequent urination or diarrhea	<input type="radio"/> Shortness of breath
<input type="radio"/> Cold and clammy hands	<input type="radio"/> Hot flashes or chills
<input type="radio"/> Insomnia (difficulty sleeping)	<input type="radio"/> Dizziness
<input type="radio"/> Fatigue (Very Tired)	<input type="radio"/> Tremors, twitches, and jitters
<input type="radio"/> Sweating	<input type="radio"/> Muscle tension or aches

Have you or someone you care about (Partner/Friend) experienced any of the following thoughts or fears in the last 6 months?:

<input type="radio"/> Do you worry about the effect your loved one's substance use/abuse is having on you and your children?	<input type="radio"/> Have you ever been embarrassed by your loved one's drinking/drug using behavior?
<input type="radio"/> Are you confused, depressed, anxious and feel that your fears are overwhelming?	<input type="radio"/> Are you losing sleep over concern for a family member or friend?
<input type="radio"/> Does your loved one justify his/her substance abuse?	<input type="radio"/> Do you feel you have to cover up or hide a problem at home?
<input type="radio"/> Does your loved one often promise to stop drinking/using drugs without success?	<input type="radio"/> Do you believe you are the cause of your loved one's drinking or drug use?
<input type="radio"/> Does your loved one's substance abuse make the atmosphere in the home tense and anxious?	

Thank you for completing this survey!! You are helping us serve you better!

Have you or someone you care about (Partner/Friend) experienced any of the following problems with alcohol &/or drugs use in the last 6 months?

<input type="radio"/> Do you sometimes feel guilty about your drinking and/or drug use?	<input type="radio"/> Do you sometimes think you need to cut down on your drinking and/or drug use?
<input type="radio"/> Have you ever lost important relationships because of your alcohol or drug use?	<input type="radio"/> Have you ever neglected your obligations, your family, or your work for two or more days in a row because you were drinking and/or using drugs?
<input type="radio"/> Have you ever had any legal problems related to your drinking or drug use?	<input type="radio"/> Have you ever been in a hospital because of drinking/drug use?
<input type="radio"/> Have you ever attended a meeting of Alcoholics Anonymous or Narcotics Anonymous?	<input type="radio"/> Have you ever had any significant loss of memory (blackouts) as a result of your substance use?
<input type="radio"/> Have you ever gotten into trouble at work because of drinking or your drug use?	<input type="radio"/> Do others annoy you when they make comments about your drinking/drug use?

Have you or someone you care about (Partner/Friend) experienced any of the following symptoms in the last 6 months?

<input type="radio"/> Sad or depressed <u>mood</u> .	<input type="radio"/> Fatigue and decreased energy level.
<input type="radio"/> Profound sadness, <u>anxiety</u> , anger, irritability or <u>apathy</u> (lack of emotion).	<input type="radio"/> Have feelings of worthlessness, self-reproach or excessive or inappropriate guilt.
<input type="radio"/> Significant change in appetite or weight (loss or gain).	<input type="radio"/> Do you find it harder than usual to think clearly or concentrate.
<input type="radio"/> Find you are sleeping too much (<u>hypersomnia</u>) or not enough (<u>insomnia</u>).	<input type="radio"/> Do you have recurrent thoughts of death, <u>suicide</u> or have you ever acted on these thoughts?
<input type="radio"/> Feel regularly agitated and anxious like wringing your hands, pace or not be able to sit still?	<input type="radio"/> Reduction or loss of interest in activities you formerly found pleasurable, such as eating, sex, work, friends, hobbies and entertainment.
<input type="radio"/> Feel pessimistic or discouraged with crying spells or excessive emotional sensitivity.	<input type="radio"/> Have you experienced Fatigue, headache and stomach pains that do not respond to medication?

Do You Smoke Cigarettes? Yes No
Do you think about quitting Smoking? Yes No
Have you Ever Tried to Quit before? Yes No
How Many Times have your quit before?
 Once 2 /3 times 4 times +

Have you or someone you care about (Partner/Friend) experienced any of the following problems when you tried to quit smoking?

<input type="radio"/> Irritability	<input type="radio"/> Disorientation
<input type="radio"/> Anger	<input type="radio"/> Lightheadedness
<input type="radio"/> Hostility	<input type="radio"/> Sleep disturbances
<input type="radio"/> Anxiety	<input type="radio"/> Constipation
<input type="radio"/> Nervousness	<input type="radio"/> Mouth ulcers
<input type="radio"/> Panic	<input type="radio"/> Dry mouth
<input type="radio"/> Poor concentration	<input type="radio"/> Sore throat

Check off any of the following behaviors that you have experienced in your home or workplace in the last 6 months.

IT IS NOT OKAY if your partner/family member/roommate:

<input type="radio"/> Hits, Kicks, Shoves, strangles or hurts you in any physical way	<input type="radio"/> Falsely accuses you of cheating
<input type="radio"/> Screams at you, puts you down, threatens, ridicules or criticizes you a lot of the time.	<input type="radio"/> Makes decisions for you, including what to wear.
<input type="radio"/> Punches the wall or breaks things in anger.	<input type="radio"/> Keeps you from seeing your friends or family.
<input type="radio"/> Blames you for his/her problems	<input type="radio"/> Always checks up on you.
<input type="radio"/> Tells you no one will believe you.	<input type="radio"/> Controls your money.
<input type="radio"/> Sexually assaults, rapes or forces you to do things sexually that you do not want to do.	<input type="radio"/> Threatens you with a weapon.