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Wellness Assessment - Youth

Completing this brief questionnaire will help us provide services that meet your child's needs. Answer each question as best you can and then review your responses with your child's clinician. Shade circles like this

Child's Last Name First Name		Child's Date of	Birth: (mm/dd/yy)		
] []/			
Subscriber ID Authorizat	ion#				
Clinician Last Name First Name		Today's Date: (mm/dd/yy)		
		/	/		
Clinician ID/Tax ID Clinician Phone		State			
	-		MRef 🔾		
Visit #: O 1 or 2 O 3 to 5 Other					
	Other Relative		Other		
For questions 1-21, please think about your e	xperience in the				
Fill in the circle that best describes your child:	Never	Sometimes	Often		
1. Destroyed property	0	0	0		
2. Was unhappy or sad	\circ	0	0		
3. Behavior caused school problems	\circ	0	0		
4. Had temper outbursts	0	0	0		
5. Worrying prevented him/her from doing things	0	0	0		
6. Felt worthless or inferior	0	0	0		
7. Had trouble sleeping	0	0	0		
8. Changed moods quickly	0	0	\circ		
9. Used alcohol	0	0	0		
10. Was restless, trouble staying seated	0	0	0		
11. Engaged in repetitious behavior	\circ	0	0		
12. Used drugs	0	0	0		
13. Worried about most everything	0	0	0		
14. Needed constant attention	0	0	0		
How much have your child's problems caused:	Not at All	A Little Sc	omewhat A Lot		
15. Interruption of personal time?	0	0	0 0		
16. Disruption of family routines?	0	0	0 0		
17. Any family member to suffer mental or physical problems?	0	0	0 0		
18. Less attention paid to any family member?	0	0	0 0		
19. Disruption or upset of relationships within the family?	0	0	0 0		
20. Disruption or upset of your family's social activities?	0	0	0 0		
21. How many days in the past week was your child's usual rou	tine interrupted b	y their problen			
Answer the following only if this is your first time completi	ng this question	naire for this c	hild.		
22. In general, would you say your child's health is: O Excellent O Very Good O Good O Fair O Poor					
23. In the past 6 months, how many times did your child visit a medical doctor? O None O 1 O 2-3 O 4-5 O 6+					
24. In past month, how many days were you unable to work be	cause of your chi		Days		
25. In the past month, how many days were you able to work behow much you got done because of your child's problems?			Days		