Human Dynamics & Diagnostics, LLC
2267 Teton Plaza, Idaho Falls, ID 83404

COMPREHENSIVE DIAGNOSTIC ASSESSMENT – YOUTH

PLEASE COMPLETE ALL AREAS OF THIS FORM PRIOR TO APPOINTMENT

(1) IDENTIFYING INFORMATION

Name: _____ DOB: _____

Assessor: _____ Date of Assessment: _____

Legal Guardian(s)*: _____

*Can the person(s) identified as the legal guardian legally authorize medical treatment for the client? ☐ Yes ☐ No

*If the guardian is someone other than a parent, has proof of guardianship been provided to this agency? ☐ Yes ☐ No

☐ New Clinic Participant – No Medicaid mental health clinic services have been received in Idaho in the past 12 months

☐ Active Clinic Participant – Medicaid mental health clinic services have been received in Idaho in the past 12 months

(2) PRESENTING PROBLEM

Please state the principal reason this consultation or treatment has been requested: _____

Please describe the current episode of the child's problems/illness from the time of his/her first symptom to the present, including dates and significant events: _____

Recent stressful life events: _____

Client Name:_____

FOR CLINICIAN USE ONLY – Specific Questions Regarding Psychiatric Problems	For Clinician Use Only:
Depression – Has your child had a period of time in which he/she felt unhappy, depressed, irritable, and felt no interest in life consistently for at least two to four weeks? ☐ Yes, now. ☐ Yes, in the past. ☐ No **High Periods or Mania –** Has your child had moods that lasted one week or more in which he/she had so much energy he/she did not sleep for several nights, or felt he/she could accomplish many difficult tasks easily? Was he/she feeling so good that others commented on his/her elevated mood? ☐ Yes, now. ☐ Yes, in the past. ☐ No **Chronic Feelings of Unhappiness –** Has your child felt mildly unhappy or unable to enjoy life for many years, for no apparent reason? ☐ Yes, now. ☐ Yes, in the past. ☐ No **Suicide Attempts –** Has your child attempted suicide? ☐ Yes, now. ☐ Yes, in the past. ☐ No **Self Harm –** Besides attempting suicide, has your child attempted to do physical harm to him/herself in other ways, such as cutting or burning him/herself? ☐ Yes, now. ☐ Yes, in the past. ☐ No **Chronic Tension or Anxiety –** Has your child ever had problems with chronic anxiety, tension, nervousness, or constant worrying? Does he or she worry about minor concerns? (Not connected to anxiety attacks) ☐ Yes, now. ☐ Yes, in the past. ☐ No **Panic Attacks –** Has your child had anxiety attacks in which he/she felt like they were going to die, lose control, were very frightened, extremely anxious, or uncomfortable? ☐ Yes, now. ☐ Yes, in the past. ☐ No **Panic Associated Fears –** Has your child ever been afraid of going out of the house alone, going to the grocery store, driving or using public transportation because of fear of having a panic attack? ☐ Yes, now. ☐ Yes, in the past. ☐ No **Obsessive/Compulsive Symptoms –** Has your child had compulsions to repeat tasks such as checking things, washing hands, counting, or obsessions (ideas that make no sense but keep repeating in his/her mind?) ☐ Yes, now. ☐ Yes, in the past. ☐ No **Social Fears or Phobias –** Has your child been fearful in specific social situations, or felt uncomfortable doing things in front of other people? Does he/she worry excessively about being embarrassed or humiliated in social situations? ☐ Yes, now. ☐ Yes, in the past. ☐ No **Phobias –** Has your child had significant phobias such as heights, flying, closed spaces, insects, etc. that interfere with his/her life? ☐ Yes, now. ☐ Yes, in the past. ☐ No	

Client Name:_____

FOR CLINICIAN USE ONLY – Specific Questions Regarding Psychiatric Problems	For Clinician Use Only:
Posttraumatic Symptoms – Has your child ever experienced a very traumatic event that has continued to bother him/her or cause emotional problems later in life, such as nightmares or flashbacks of the event? ☐ Yes, now. ☐ Yes, in the past. ☐ No **Hyperactivity/Inattention –** Was/is your child considered hyperactive and/or inattentive, been treated with Ritalin or another stimulant, or been diagnosed with ADHD? ☐ Yes, now. ☐ Yes, in the past. ☐ No **Psychotic Symptoms –** Has your child had hallucinations, heard voices, felt that he/she had special powers or were receiving special messages, felt inappropriately suspicious that people were trying to hurt him/her? ☐ Yes, now. ☐ Yes, in the past. ☐ No **Chronic Physical Symptoms –** Has your child had a period of time in which he/she felt physically sick or worried about his/her health when no physical cause could be found? ☐ Yes, now. ☐ Yes, in the past. ☐ No **Chronic Pain –** Has your child had problems with chronic pain such as headaches or stomachaches? If so please specify:_____ ☐ Yes, now. ☐ Yes, in the past. ☐ No **Sleep Problems –** Has your child experienced sleep problems such as insomnia, oversleeping, frequent nightmares or sleepwalking? ☐ Yes, now. ☐ Yes, in the past. ☐ No **Anorexia –** Has your child ever been anorexic or purposely lost weight to obtain a weight below normal? ☐ Yes, now. ☐ Yes, in the past. ☐ No **Binge Eating or Bulimia –** Has your child had eating binges associated with inducing vomiting, using laxatives, or exercising to extreme? ☐ Yes, now. ☐ Yes, in the past. ☐ No **Compulsive Behaviors –** Has your child had problems with compulsive behaviors such as gambling, spending, work, sex, pornography, or other problematic compulsions? ☐ Yes, now. ☐ Yes, in the past. ☐ No **Temper/Anger Problems –** Has your child had problems with his/her temper? ☐ Yes, now. ☐ Yes, in the past. ☐ No **Oppositional Behaviors –** Does your child argue with adults, defy rules, deliberately annoy others, blame others for his/her misbehavior, or act easily annoyed more that his/her peers? ☐ Yes, now. ☐ Yes, in the past. ☐ No **Conduct Disorder Problems –** Has your child repetitively exhibited threatening behavior, cruelty to animals, fire-setting, destruction of property, shoplifting, stealing, lying, running away, running away, truancy, gang activity, etc.? ☐ Yes, now. ☐ Yes, in the past. ☐ No	

Client Name:_____

(3) BEHAVIORAL HEALTH TREATMENT HISTORY

	Who provided the service?	When and how often?	Was it helpful? Please explain.
Counseling			
Medication Management			
Family Therapy			
Case Management			
CBRS/PSR			
Addictions Treatment			
Developmental Services			
Occupational Therapy			
Speech Therapy			
Physical Therapy			
IEP or 504 Plan			
Personal Care Services			
Other			

Has your child been admitted to a residential treatment program or psychiatric hospital? ☐ No ☐ Yes – please complete:

Institution	Reason for admission	Date	Length of stay	Did it help?

(4) SUBSTANCE USE/ABUSE

Alcohol Use/Abuse – Does your child drink alcohol? ☐ Yes, now ☐ Yes, in the past ☐ No

☐ He/she drinks occasionally: _____ x per month ☐ He/she drinks most days: _____ x per week

☐ I believe he/she has a drinking problem.

Drug Abuse – Has your child abused "street" or prescription drugs? ☐ Yes, now ☐ Yes, in the past ☐ No

If yes, what drug(s) and what ages with each drug? _____

_____

Smoking/Vaping/Other – Do you smoke, use other tobacco products, or vape? ☐ Yes, now ☐ Yes, in the past ☐ No

If yes how much per day/week and for how long? _____

Caffeine – Does your child regularly drink coffee, tea or colas? ☐ No ☐ Yes – How much? _____

Clinician Comments:

Client Name:_____

(5) FAMILY PSYCHIATRIC HISTORY

Please include psychiatric problems in your child's biological relatives. Consider problems such as depression, bipolar disorder, anxiety disorders (OCD, panic disorder, PTSD), schizophrenia, ADHD, alcohol or drug abuse, anger or criminal problems, suicides, etc.

Relative	Yes	No	?	Type(s) of problem(s)
Child's Mother				
Mother's Relatives				
Child's Father				
Father's Relatives				
Child's Siblings				

(6) MEDICAL HISTORY & FUNCTIONING

How is your child's general health? ☐ Good ☐ Fair ☐ Poor

Medical Doctors/Specialists: _____

_____

History of significant illness or medical treatment in the family: _____

_____

Health Conditions - Check any health conditions that apply:

☐ Thyroid problem	☐ High blood pressure	☐ Headaches
☐ Heart problem	☐ Sleep problems	☐ High cholesterol
☐ Asthma	☐ Trouble eating	☐ Other: _____
☐ Stomach problems	☐ Seizures	☐ Other: _____

Does your child have

any contagious diseases? ☐ No ☐ Yes What/When: _____

any disabilities or handicaps? ☐ No ☐ Yes What/When: _____

any allergies? ☐ No ☐ Yes What/When: _____

Client Name: _____

Has your child had any

accidents/injuries? ☐ No ☐ Yes What/When: _____

surgeries? ☐ No ☐ Yes What/When: _____

major illnesses? ☐ No ☐ Yes What/When: _____

hospitalizations? ☐ No ☐ Yes What/When: _____

loss of consciousness? ☐ No ☐ Yes What/When: _____

Menstrual History – What was the date of your child's last menstrual period? _____

Does your daughter have any history of:

premenstrual syndrome? ☐ No ☐ Yes What/When: _____

amenorrhea (absence of periods)? ☐ No ☐ Yes What/When: _____

irregular periods? ☐ No ☐ Yes What/When: _____

pregnancy? ☐ No ☐ Yes What/When: _____

Current Medication - Please list all current prescribed or over-the-counter drugs/medications.

☐ No medications

Medication: _____ Dosage: _____ Doctor: _____

Medication: _____ Dosage: _____ Doctor: _____

Medication: _____ Dosage: _____ Doctor: _____

Medication: _____ Dosage: _____ Doctor: _____

Medication: _____ Dosage: _____ Doctor: _____

Medication: _____ Dosage: _____ Doctor: _____

Can your child self-administer his/her medication? ☐ No ☐ Yes

Medication compliance: ☐ Regularly taken as prescribed ☐ Occasionally misses a dose

☐ Misses doses regularly ☐ Refuses/forgets to take meds most days

Past Medication - Has your child been treated in the past with psychiatric medication? ☐ No ☐ Yes – please complete:

Antidepressants		Mood Stabilizers	Tranquilizers	Sleeping Aids	Stimulants	Others
Prozac	Serzone	Lithium	Xanax	Ambien	Ritalin	Rispedal
Zoloft	Wellbutrin	Depakote	Klonopin	Sonata	Dexedrine	Zyprexa
Paxil	Amitriptyline	Tegretol	Ativan	Trazodone	Adderall	Seroquel
Luvox	Nortriptyline	Lamictal	Valium		Clonidine	Haldol
Celexa	Desipramine	Neurontin	Buspar		Concerta	Prolixin
Effexor	Anafranil	Abilify			Provigil	Thorazine
Remeron					Vyvanse	Trilafon
					Strattera	Antabuse

Clinician Comments:

Client Name:_____

DEVELOPMENTAL HISTORY

Early Development - Did your child or his/her mother experience any significant medical problems during the pregnancy, labor, delivery, or newborn period? ☐ No ☐ Yes – please explain: _____

_____

Was his/her mother using alcohol, cigarettes, or illicit drugs during the pregnancy? ☐ No ☐ Yes – please explain: _____

_____

Did your child ever spend a significant period of time separated from his/her primary caregiver(s) for any reason?

☐ No ☐ Yes – please explain: _____

_____

Have you or your child's pediatrician ever expressed concerns about your child's development? ☐ No ☐ Yes – please explain: _____

_____

Clinician Comments:

(7) FAMILY HISTORY & FUNCTIONING

Place of child's birth: _____

Parents at the time of birth were: ☐ Married ☐ Separated ☐ Unmarried

Are the parents divorced? If so, when?_____Remarriages? _____

Father's Name: _____ Mother's Name: _____

Where is he living: _____ Where is she living: _____

Stepmother's Name: _____ Stepfather's Name: _____

Custody: ☐ Lives in one home with both legal parents. ☐ Mother has physical custody.

☐ Father has physical custody. ☐ Physical custody is shared.

☐ Other: _____

Household members:	Name	Age	Relationship
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Client Name: _____

Siblings not in household: Name Age Relationship

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

If any brothers/sisters are deceased, please give name and year: _____

Was the child adopted? ☐ No ☐ Yes – Age at time of adoption: _____ Circumstances: _____

_____

FAMILY HISTORY:

Has the child ever been placed outside of the home? ☐ No ☐ Yes – please explain: _____

_____

_____

Has the child been physically or sexually abused, assaulted or molested? ☐ No ☐ Don't know ☐ Yes – please specify when and by whom: _____

_____

_____

Please describe the child's relationship with his/her

Father: _____

Mother: _____

Siblings: _____

Stepparent(s): _____

Please describe the type of structure and discipline used in the home: _____

_____

_____

Please explain your family's cultural and/or spiritual background: _____

_____

Where did the child live while he/she was growing up? Did the family move frequently? _____

_____

What resources and supports does the child/family have? _____

_____

_____

What are the child's strengths in the family setting? _____

_____

Clinician Comments:

Client Name:_____

(8) SOCIAL HISTORY & FUNCTIONING

How would you describe your child's friendships? ☐ No friends ☐ Only acquaintances ☐ Acquaintances & Friends

How would you describe your child's behavior when he/she is in social situations? _____

_____

_____

Has your child experienced any difficulties related to age, gender, sexual orientation, culture, race, or religion? ☐ No ☐ Yes – please explain: _____

Is your child sexually active or does he/she demonstrate overly sexualized behavior? ☐ No ☐ Yes – please explain (number of partners, risky behavior, etc): _____

_____

_____

What leisure/recreational/extracurricular activities is your child involved in? _____

_____

What are your child's talents and social strengths? _____

_____

Clinician Comments:

(9) VOCATIONAL/EDUCATIONAL HISTORY & FUNCTIONING

Education - School: _____ Grade Level: _____

Is your child in a specialized classroom setting or receive special education? ☐ No ☐ Yes – please explain: _____

_____

Regarding school, has your child ever

had an IEP or 504 plan? ☐ No ☐ Yes – please explain: _____

been tutored? ☐ No ☐ Yes – please explain: _____

been suspended? ☐ No ☐ Yes – please explain: _____

been expelled? ☐ No ☐ Yes – please explain: _____

Have you been contacted by school personnel because of your child's school performance or behavior? ☐ No ☐Yes – please explain: _____

What are the average grades your child received:

in elementary school? _____

in junior high? _____

in high school? _____

What are your child's strengths/talents in the school setting? _____

Client Name:_____

Employment - Has your child ever been employed? ☐ No ☐ Yes – please describe job(s) and duration of employment: ___

_____

Has your child ever

been reprimanded at work? ☐ No ☐ Yes – please explain: _____

been fired from a job? ☐ No ☐ Yes – please explain: _____

participated in a work program? ☐ No ☐ Yes – please explain: _____

What are your child's work skills/interests? _____

Clinician Comments:

(10) FINANCIAL HISTORY & FUNCTIONING

Please describe the family's source(s) of income: _____

Are finances adequate to meet the family's needs? ☐ Yes ☐ No – please explain problems and supports/resources available:

_____

Does the child/family receive

child support? ☐ No ☐ Yes – amount/frequency: _____

SSDI? ☐ No ☐ Yes – amount/frequency: _____

SSI? ☐ No ☐ Yes – amount/frequency: _____

food stamps? ☐ No ☐ Yes – amount/frequency: _____

cash assistance? ☐ No ☐ Yes – amount/frequency: _____

other income? ☐ No ☐ Yes – amount/frequency:_____

Please explain any financial responsibilities/obligations your child has and how he/she manages these responsibilities: _____

_____

_____

Clinician Comments:

Client Name:_____

(11) BASIC LIVING SKILLS HISTORY & FUNCTIONING

Please indicate your child's habits with regard to the following basic living skill practices:

Bathing (using soap, washing hair) ☐ Daily ☐ A few times per week ☐ Once per week or less

Brushing teeth ☐ Daily ☐ A few times per week ☐ Once per week or less

Dress in clean/appropriate clothes ☐ Daily ☐ A few times per week ☐ Once per week or less

Does your child require repeated prompting in order to accomplish any of these hygiene tasks? ☐ No ☐ Yes

Is your child able to perform the following basic safety skills?

Call 911 in an emergency? ☐ Yes ☐ No

Refrain from playing with matches or other fire hazards? ☐ Yes ☐ No

Use adequate caution when crossing the street? ☐ Yes ☐ No

Use adequate caution when engaging with strangers (is she/he aware of stranger danger?) ☐ Yes ☐ No

Lock doors and use a key? ☐ Yes ☐ No

Please indicate your child's care of his/her personal possessions: ☐ Good care/age appropriate ☐ Careless ☐ Destructive

Will your child be turning 18 soon and/or preparing to live on his/her own? ☐ No ☐ Yes – if "yes", please indicate your child's ability to do the following:

Prepare meals ☐ Good ☐ Fair ☐ Poor

Shop for items ☐ Good ☐ Fair ☐ Poor

Develop regular schedules/routines ☐ Good ☐ Fair ☐ Poor

Clinician Comments:

(12) HOUSING HISTORY & FUNCTIONING

Does the current housing situation meet the child's needs in the following areas?

Health and safety? ☐ Yes ☐ No – please explain: _____

Access to services? ☐ Yes ☐ No – please explain: _____

Is there any history of homelessness? ☐ No ☐ Yes – please explain: _____

Is there any risk of homelessness? ☐ No ☐ Yes – please explain: _____

Clinician Comments:

Client Name: _____

(13) COMMUNITY/LEGAL HISTORY & FUNCTIONING

Does the child have any current or past involvement with the following?

Diversion Court ☐ No ☐ Yes, please explain: _____

Probation ☐ No ☐ Yes, please explain: _____

Arrest ☐ No ☐ Yes, please explain: _____

Illegal activity ☐ No ☐ Yes, please explain: _____

Juvenile detention ☐ No ☐ Yes, please explain: _____

Does your child have transportation to and from school, appointments, etc? ☐ Yes ☐ No – please explain: _____

_____

Does your child have a

Social Security card? ☐ Yes ☐ No Driver's license? ☐ Yes ☐ No

Clinician Comments:

(14) CLIENT/PARENT SIGNATURE

Name of Person completing this form: _____ Relationship to Client: _____

Signature: _____ Date: _____

Client Name:_____

THIS SECTION IS FOR CLINICIAN USE ONLY. PLEASE DO NOT COMPLETE THIS SECTION.

(15) MENTAL STATUS EXAM

SUICIDALITY/HOMICIDALITY

☐ Client denies any **current** suicidal or homicidal thoughts, feelings, gestures, intentions or plans.

☐ Client reports **current** suicidal or homicidal feelings.

Specify: _____

☐ Client denies **history** of suicidal or homicidal thoughts, feelings, gestures, intentions or plans.

☐ Client has **history** of suicidal or homicidal thoughts, feelings, gestures, intentions or plans.

Specify: _____

Immediate Therapist intervention needed:_____(☐ None needed)

MENTAL STATUS

General Behavior: cooperative, passive, withdrawn, dramatic, restless, hostile, anxious, other: _____

Attire: appropriate, seductive, untidy, loud, meticulous, other: _____

Motor Activity: normal, agitated, retarded, tremor, tic, mannerism, other: _____

Productivity of thought: spontaneous, verbose, pressured speech, unproductive, other: _____

Progression of thought: normal, loose, circumstantial, preservation, halting, blocking, incoherent, fragmented, other: _____

Language: normal, baby-talk, peculiar, expression, stilted, other: _____

Mood: indifferent, fearful, angry, euphoric, labile, shallow, blunted, flat, normal, composed, anxious, sad, tearful, depressed

Affect: appropriate, inappropriate, other: _____

Perception: normal, auditory hallucination, visual hallucination, illusions, depersonalization, hypochondriasis, other: _____

Orientation: normal, disoriented to time, place, person

Memory: normal, defective (remote, recent, immediate), other: _____

General knowledge: consistent with education, inconsistent, able to abstract, concrete, other: _____

Insight: absent, good, fair, minimal

Judgment: good, fair, poor

(16) CLINICIAN SIGNATURES (The CDA must be signed and dated by all professionals who contribute to its development – PSR staff, etc)

_____

Therapist's Signature Date

_____

Other Date

Client Name:_____

For Medicaid Clients Only
If insurance is not Medicaid please disregard

ICANS Informed Consent

I, _____ *(parent's name)*, am the parent or legal guardian of

_____ (minor client's name).

I have received a brochure explaining how ICANS is a secure electronic health system used to administer the ICANS assessment, and make the results available to providers who participate in the ICANS system.

I authorize the following Agency _____ (*name of provider/agency/ organization)* to release, use, receive, mutually exchange, communicate with and disclose information to the ICANS system, and with Agencies/Authorized Users with access to ICANS.

WHO MAY DISCLOSE INFORMATION. The agency I have named at the top of this form may disclose protected health information to ICANS.

WHAT MAY BE DISCLOSED. By signing this consent, I specifically understand that protected health information or records will be released, used, disclosed, received, mutually exchanged or communicated to, by, among, or between any person, entity, or agency named in this authorization. I understand this information may include material protected under federal regulations governing confidentiality of alcohol and drug abuse patient records, 42 C.F.R. Part 2; the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160 & 164; and the Medicaid Act, 42 CFR Part 431, Subpart F. Federal rules restrict any use of the information to criminally investigate or prosecute and to redisclose records relating to any alcohol or drug abuse patient.

PURPOSES.
I understand this authorization will allow my treatment team to plan and coordinate services I need and allows any person, entity, or agency named in this authorization to be actively involved in my case coordination, evaluation, treatment, planning, or legal proceedings. I hereby request and give my permission for an open exchange of information to, by, among, or between, any person, entity, or agency named in this authorization.

REVOCATION.
I also understand that I may revoke this Informed Consent at any time, except to the extent that action has been taken in reliance on it and that in any event this authorization expires automatically as indicated with each disclosure item identified above. A photocopy or exact reproduction of this signed authorization shall have the same force and effect as this original.

Client Name:_____

EXPIRATION
This authorization shall expire one (1) year from the date the Minor Client and Parent or Legal Guardian signs below.

CONSENT.
I understand that my information cannot be disclosed without my written consent, except as otherwise provided by law, and that federal and Idaho law will be followed for using and disclosing my ICANS information.

By signing this form, I am authorizing providers assessing or treating my child/ward to provide my child/ward's information to ICANS. I understand that failure to sign this authorization may limit determine of eligibility, enrollment, or treatment for my child/ward.

I have read this Informed Consent/had this Informed Consent read/explained to me and I acknowledge an understanding of the purpose for the release of information. I am signing this authorization of my own free will.

Full Legal Signature of Minor or Authorized Personal Representative	**Relationship to Client**	**Date**
Full Legal Signature of Parent or Legal Guardian – *Required if Client is under 16 years of age, but only after signed by client.*	**Relationship to Client**	**Date**
Full Legal Signature of Witness (Agency Employee)	**Initiating Agency Name**	**Date**

Wellness Assessment

What is the purpose of the Wellness Assessment?
The Wellness Assessment is a set of questions to help your Care Advocate at your insurance company understand how you are doing in treatment. It helps the Care Advocate in working with your therapist so that you receive the services you need. The direction of your therapy is the result of the treatment decisions that you make together with your therapist.

How long will it take me to complete the Wellness Assessment?
Completing the form only takes a few moments of your time. Discuss with your therapist anything on the Wellness Assessment that you find important.

Are my answers confidential?
Yes. Your responses on the Wellness Assessment are considered Protected Health Information and are kept confidential. Your insurance company follows the guidelines of the national Health Insurance Portability and Accountability Act (HIPAA) as set by the United States Department of Health and Human Services.

Will my responses affect my benefits?
No. Your answers on this Wellness Assessment will not affect your insurance coverage or eligibility.

Will all the Wellness Assessments I complete be done at my therapist's office?
No. About four months after the date you start treatment, you will receive a Wellness Assessment in the mail directly from your insurance company. A business reply envelope will be included. Simply complete the Wellness Assessment and return it in the envelope provided.

Visit www.liveandworkwell.com. It contains useful information on a variety of topics to help you take charge of your health and well-being.

ALERT ® 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. Then review your responses with your child's clinician. Please shade circles like this ●

Child's Name | Child's Date of Birth

Subscriber ID | Authorization #

Clinician Name | Today's Date (mm/dd/yy)

Clinician ID/Tax ID: 800104889 | Clinician Phone: (208) 522-0140 | State: ID | *MRef* ☐

Visit #: ○ 1 or 2 ○ 3 to 5 ○ Other

Relationship to child: ○ Mother ○ Father ○ Stepparent ○ Other Relative ○ Child/Self ○ Other

For questions 1-21, please think about your experience in the past week.

Fill in the circle that best describes your child:	*Never*	*Sometimes*	*Often*
1. Destroyed property	○	○	○
2. Was unhappy or sad	○	○	○
3. Behavior caused school problems	○	○	○
4. Had temper outbursts	○	○	○
5. Worrying prevented him/her from doing things	○	○	○
6. Felt worthless or inferior	○	○	○
7. Had trouble sleeping	○	○	○
8. Changed moods quickly	○	○	○
9. Used alcohol	○	○	○
10. Was restless, trouble staying seated	○	○	○
11. Engaged in repetitious behavior	○	○	○
12. Used drugs	○	○	○
13. Worried about most everthing	○	○	○
14. Needed constant attention	○	○	○

How much have your child's problems caused:	*Not at All*	*A Little*	*Somewhat*	*A Lot*
15. Interruption of personal time?	○	○	○	○
16. Disruption of family routines?	○	○	○	○
17. Any family member to suffer mental or physical problems?	○	○	○	○
18. Less attention paid to any family member?	○	○	○	○
19. Disruption or upset of relationships within the family?	○	○	○	○
20. Disruption or upset of your family's social activities?	○	○	○	○

21. How many days in the last week was your child's usual routine interrupted by their problems? ☐ Days

Answer the following questions only if this is your first time completing this questionnaire for this child.

22. In general, would you say your child's health is: ○ Excellent ○ Very Good ○ Good ○ Fair ○ Poor
23. In the past 6 months, how many times did your child visit a medical doctor? ○ None ○ 1 ○ 2-3 ○ 4-5 ○ 6+
24. In the past month, how many days were you unable to work because of your child's problems? *(answer only if employed)* ☐☐ Days
25. 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 child's problems? *(answer only if employed)* ☐☐ Days