

**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: \_\_\_\_\_  
 \_\_\_\_\_  
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Recent stressful life events: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**FOR CLINICIAN USE ONLY – Specific Questions Regarding Psychiatric Problems**

**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

**For Clinician Use Only:**

**FOR CLINICIAN USE ONLY – Specific Questions Regarding Psychiatric Problems**

**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 than 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

**For Clinician Use Only:**

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	Dates 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:

<u>Antidepressants</u>		<u>Mood Stabilizers</u>	<u>Tranquilizers</u>	<u>Sleeping Aids</u>	<u>Stimulants</u>	<u>Others</u>
Prozac	Serzone	Lithium	Xanax	Ambien	Ritalin	Risperdal
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: \_\_\_\_\_

Please indicate the child’s sexual orientation: \_\_\_\_\_  
gender: \_\_\_\_\_

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, or been a perpetrator?  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:**

**(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: \_\_\_\_\_

**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.

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

# 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](http://www.liveandworkwell.com). It contains useful information on a variety of topics to help you take charge of your health and well-being.



# ALERT<sup>®</sup>

# 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
<input type="text"/>	<input type="text"/>

Subscriber ID	Authorization #
<input type="text"/>	<input type="text"/>

Clinician Name	Today's Date (mm/dd/yy)
<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

Clinician ID/Tax ID	Clinician Phone	State	MRef <input type="radio"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	

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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Was unhappy or sad	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Behavior caused school problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Had temper outbursts	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Worrying prevented him/her from doing things	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Felt worthless or inferior	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. Had trouble sleeping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. Changed moods quickly	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. Used alcohol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. Was restless, trouble staying seated	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. Engaged in repetitious behavior	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. Used drugs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13. Worried about most everthing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. Needed constant attention	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

How much have your child's problems caused:	Not at All	A Little	Somewhat	A Lot
15. Interruption of personal time?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16. Disruption of family routines?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17. Any family member to suffer mental or physical problems?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18. Less attention paid to any family member?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
19. Disruption or upset of relationships within the family?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20. Disruption or upset of your family's social activities?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
21. How many days in the last week was your child's usual routine interrupted by their problems?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="text"/> 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