

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 |
| <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