Youth Pre-Treatment Wellness Assessment

Child's Name: _____ Today's Date: _____/_____/_____

Relationship to Child: _____

Think about your experience in the past week…

Check the box that best describes your child:	***Never***	***Rarely***	***Sometimes***	***Often***	***All the Time***
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 everything					
14. Needed constant attention					

How much has your child's problem caused:	***Never***	***Rarely***	***Sometimes***	***Often***	***All the Time***
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 other family member?					
19. Disruption or upset of relationships within the family?					
20. Disruption or upset of your family's social activities?					
21. Unable to go to work because of your child's problems?					

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 visit*** ☐ ***2-3 visits*** ☐ ***4-5 visits*** ☐ ***6+ visits*** ☐