

Wellness Assessment - Child

New Patient Registration Form:

Please email these forms to michael.cornwall@cornwallcounseling.com There is no need to sign any of the registration forms.

Last Name	First Name			DOB mm/dd/yyyy		
Subscriber's ID	A	Today's Date mm/dd/yyyy				
Visit #:	Relationship to Child	b				
1 or 2	Mother	Father	Stepparent	Other relative		
3 to 5	Child/Self	Other				
Other						

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

	Never	Sometimes	Often
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 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 relationships within the family				
20. Disruption or upset your family's social activities?				

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

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

23. In the last 6 months, how many times did your child visit a medical

22. In general, your child's health is: doctor?

Excellent None
Very Good 1
Good 2-3
Fair 4-5
Poor 6+

- 24. In the past month, how many days were you unable to work because of your child's problems? (answer only if employed)
- 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)