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CHILD/ADOLESCENT/TEEN (16 AND UNDER) WELLNESS ASSESSMENT

Last Name

First Name

DOB

EAP Provider

Authorization #

Today's Date

Visit #:

- 1 or 2
 3 to 5
 Other

Relationship to Child

- Mother Father Stepparent Other relative
 Child/Self Other

Please describe what you believe is your goal in counseling.

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

	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 everything	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. Needed constant attention	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

What do you like to do with your spare time? i.e., hobbies, interests, etc.

How much has your child's issues 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 relationships within the family	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20. Disruption or upset your family's social activities?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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

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

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

- Excellent
- Very Good
- Good
- Fair
- Poor

23. In the last 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*)

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*)

Other Comments: