

Completing this brief questionnaire will help us provide services that meet your child's needs. Answer each question as best you can and then review your responses with your child's clinician. Shade circles like this ●

Child's Last Name  , First Name  Child's Date of Birth: (mm/dd/yy)  /  /

Subscriber ID  Authorization #

Clinician Last Name  , First Name  Today's Date: (mm/dd/yy)  /  /

Clinician ID/Tax ID  Clinician Phone  -  State  MRef

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:**

	<i>Never</i>	<i>Sometimes</i>	<i>Often</i>
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"/>

**How much have your child's problems caused:**

	<i>Not at All</i>	<i>A Little</i>	<i>Somewhat</i>	<i>A Lot</i>
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 past week was your child's usual routine interrupted by their problems?				<input type="text"/> Days

**Answer the following 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 past month, how many days were you unable to work because of your child's problems?  Days  
(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?  Days  
(answer only if employed)

