Wellness Assessment

What is the purpose of the Wellness Assessment?

The Wellness Assessment is a set of questions to help your Care Advocate at your insurance company understand how you are doing in treatment. It helps the Care Advocate in working with your therapist so that you receive the services you need. The direction of your therapy is the result of the treatment decisions that you make together with your therapist.

How long will it take me to complete the Wellness Assessment?

Completing the form only takes a few moments of your time. Discuss with your therapist anything on the Wellness Assessment that you find important.

Are my answers confidential?

Yes. Your responses on the Wellness Assessment are considered Protected Health Information and are kept confidential. Your insurance company follows the guidelines of the national Health Insurance Portability and Accountability Act (HIPAA) as set by the United States Department of Health and Human Services.

Will my responses affect my benefits?

No. Your answers on this Wellness Assessment will not affect your insurance coverage or eligibility.

Will all the Wellness Assessments I complete be done at my therapist's office?

No. About four months after the date you start treatment, you will receive a Wellness Assessment in the mail directly from your insurance company. A business reply envelope will be included. Simply complete the Wellness Assessment and return it in the envelope provided.

Visit <u>www.liveandworkwell.com</u>. It contains useful information on a variety of topics to help you take charge of your health and well-being.

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 and then review your responses with your child's clinician. Shade circles like this

Child's Last Name First Name		Child's Date of	f Birth: (mm/dd/yy)
		/	
Subscriber ID Authorizat	ion#		
Clinician Last Name First Name		Today's Date:	(mm/dd/yy)
Clinician ID/Tax ID Clinician Phone		State	14D 60
	-		MRef 🔾
Visit #: O 1 or 2 O 3 to 5 O Other	_		
Relationship to child: O Mother O Father O Stepparent O Other Relative O Child/Self O 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			
Fill in the circle that best describes your child:	Never	Sometimes	~
1. Destroyed property	0	0	0
2. Was unhappy or sad	0	O	0
3. Behavior caused school problems	0	O	0
4. Had temper outbursts	0	0	0
5. Worrying prevented him/her from doing things	O	O	0
6. Felt worthless or inferior	O	O	0
7. Had trouble sleeping	O	Ö	0
8. Changed moods quickly	0	0	0
9. Used alcohol	0	0	0
10. Was restless, trouble staying seated	0	0	0
11. Engaged in repetitious behavior	0	\circ	0
12. Used drugs	0	0	0
13. Worried about most everything	0	0	0
14. Needed constant attention	0	0	0
How much have your child's problems caused:	Not at All	A Little So	omewhat A Lot
15. Interruption of personal time?	0	0	0 0
16. Disruption of family routines?	Ö	Ö	0 0
17. Any family member to suffer mental or physical problems?	0	0	0 0
18. Less attention paid to any family member?	0	0	0 0
19. Disruption or upset of relationships within the family?	0	0	0 0
20. Disruption or upset of your family's social activities?	0	0	0 0
21. How many days in the past week was your child's usual rou	tine interrupted	by their problen	ns? Days
Answer the following only if this is your first time completing this questionnaire for this child.			
	lent O Very		
23. In the past 6 months, how many times did your child visit a medical doctor? O None O 1 O 2-3 O 4-5 O 6+			
24. In 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 b	•		Days
how much you got done because of your child's problems?		ly if employed)	Days

Clinician: Please fax to (800) 985-6894

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