United Behavioral Health | U.S. Behavioral Health Plan, California

Initial Wellness Assessment
(Child & Adolescent)

Every parent whose child uses services through United Behavioral Health (UBH) or U.S. Behavioral Health Plan, California (USBHPC) is asked to complete this brief questionnaire. It will help us measure whether the services were helpful in meeting your child's needs. Please answer each item as best you can, based on how your child and family are feeling today. We encourage you to discuss your answers with your child's clinician. That way, together you can achieve the best possible results.

We may review your answers to see if we can offer your family additional resources or support. We may also review your answers with your child's clinician if we believe that will help your child. We respect your privacy and confidentiality. Your answers will not be revealed to your employer or health plan.

Your response is very important to us. It is one of the best ways we can understand your concerns and help your child get the assistance he or she needs. While we urge you to complete this questionnaire, you are not required to do so. This questionnaire will not affect your child's eligibility for services through UBH or USBHPC.

If you have any questions about this questionnaire, please call the number on the back of your enrollee identification card.

Child/Adolescent Information (Please print. All fields are required.)

First Name: _____ Last Name: _____

Date of Birth: __ / __ / ____ Gender: ☐ Male ☐ Female Subscriber ID: _____

1. What is your relationship to the child for whom you will be completing this questionnaire?

- ❍ Mother
- ❍ Father
- ❍ Stepmother
- ❍ Stepfather
- ❍ Grandmother
- ❍ Grandfather
- ❍ Foster parent
- ❍ Other

2. Please indicate your child's PRIMARY problem that has led you to seek help for him or her today.

- ❍ Sad or depressed mood
- ❍ Anxiety, worries, or fears
- ❍ Problems within family
- ❍ Problems with peers
- ❍ Problems functioning at school
- ❍ Substance use problems
- ❍ Physical health problems
- ❍ Other emotional/psychological problems
- ❍ Other behavioral problems

	Not at all	A little	Somewhat	Quite a bit	Very much
3. In the past 30 days, how much have your child's problems that led you to seek help bothered …					
a. … your child?	❍	❍	❍	❍	❍
b. … you?	❍	❍	❍	❍	❍

4. How long has your child had the problem for which you are seeking treatment?

- ❍ Less than 1 month
- ❍ 1-3 months
- ❍ 4-6 months
- ❍ 7-12 months
- ❍ One or more years

	Excellent	Very Good	Good	Fair	Poor
5. In general, would you say your child's health is:	❍	❍	❍	❍	❍

		Yes		No	
6. Does your child currently have a serious and/or chronic medical condition such as diabetes or asthma? If yes, please print the medical condition(s) _____		❍		❍	

	zero	1	2-3	4-5	More than 5
7. In the past six months, how many times has your child seen a medical doctor or used other medical services?	❍	❍	❍	❍	❍

Please continue on the next page

Child's/Adolescent's Name (please print): _____

	No problem		Some problems		A big problem
8. In general, how much of a problem do you think your child has with the following? *If questions 8b, 8c, and 8g about a mother and father do not apply for this child, please think of the primary female or male caregiver in the child's life when answering.*					
a. Getting into trouble.	❍	❍	❍	❍	❍
b. Getting along with his or her mother.	❍	❍	❍	❍	❍
c. Getting along with his or her father.	❍	❍	❍	❍	❍
d. Feeling unhappy or sad.	❍	❍	❍	❍	❍
e. His or her behavior at school (or at work).	❍	❍	❍	❍	❍
f. Having fun.	❍	❍	❍	❍	❍
g. Getting along with adults other than his or her mother and father.	❍	❍	❍	❍	❍
h. Feeling nervous or worried.	❍	❍	❍	❍	❍
i. Getting along with his or her brothers or sisters.	❍	❍	❍	❍	❍
j. Getting along with other kids his or her age.	❍	❍	❍	❍	❍
k. Getting involved in activities like sports or hobbies.	❍	❍	❍	❍	❍
l. His or her schoolwork (or doing his or her job).	❍	❍	❍	❍	❍
m. His or her behavior at home.	❍	❍	❍	❍	❍

	Not at all	A little	Somewhat	Quite a bit	Very much
9. How much have your child's problems caused…					
a. …interruption of personal time?	❍	❍	❍	❍	❍
b. …disruption of family routines?	❍	❍	❍	❍	❍
c. …any family member having to do without things?	❍	❍	❍	❍	❍
d. …any family member to suffer negative mental or physical health?	❍	❍	❍	❍	❍
e. …financial strain for your family?	❍	❍	❍	❍	❍
f. …less attention to be paid to any family member because of attention given to your child?	❍	❍	❍	❍	❍
g. …disruption or upset of relationships within the family?	❍	❍	❍	❍	❍
h. …disruption of your family's social activities?	❍	❍	❍	❍	❍
i. …you to miss work or neglect other duties?	❍	❍	❍	❍	❍

		Yes		No	
10. Are you currently employed? (If yes, please proceed to question 11 below. If no, please skip to question 13 below.)		❍		❍	

11. During the past 30 days, how many days were you unable to work because of your child's problems or your own physical or mental health? [ ] Days

12. During the past 30 days, how many days did you work, but had to cut back on how much you got done because of your child's problems or your own physical or mental health? [ ] Days

		Yes		No	
13. To your knowledge, has your child used alcohol or drugs in the past 30 days?		❍		❍	

	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
14. Please tell us how much you agree with the following statements regarding UBH/USBHPC:					
a. The information and resources I received were useful.	❍	❍	❍	❍	❍
b. Calls were answered in a reasonable time.	❍	❍	❍	❍	❍
c. I received information I requested in a reasonable time.	❍	❍	❍	❍	❍
d. The staff were helpful.	❍	❍	❍	❍	❍
e. If the need arose I would use these services again.	❍	❍	❍	❍	❍

Please continue on the next page

Child's/Adolescent's Name (please print): _____

	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
15. Please tell us how much you agree with the following statements regarding finding a clinician:					
a. I was satisfied with my experience of finding an available clinician.	❍	❍	❍	❍	❍
b. My child's first appointment with a clinician took place within an acceptable timeframe.	❍	❍	❍	❍	❍

16. We would like to see how well we serve different ethnic groups. Please indicate with what ethnic group your child identifies most:

- ❍ White, non-hispanic
- ❍ African American or Black
- ❍ Latino or Hispanic
- ❍ American Indian or Alaska native
- ❍ Asian or Pacific Islander
- ❍ Multiple ethnic groups
- ❍ Other ethnic groups
- ❍ Do not wish to disclose

	Yes	No
17. In order for us to measure the helpfulness of our services to you, may we mail you a brief Follow-up Wellness Assessment in a few months?	❍	❍

Thank you for taking the time to complete our Wellness Assessment.

Please review your responses with your child's clinician.

For Clinician Use (Please print. All fields are required.)

Clinician Name

First Name: _____ Last Name: _____

Phone Number: (___) ___ - ____ Authorization Number: _____

Date assessment given to parents: __ / __ / ____

If parents did not agree to complete the assessment, please initial here _____.

NOTE: You must submit this form to UBH/USBHPC to notify us of treatment, whether the parent chose to complete it or not. Please be sure the "Child Information" box on page 1 is complete before you do so.

Reviewing the parent's responses helps enhance treatment planning and assess outcomes.

Please indicate that you have reviewed the responses with your client's parents by initialing here _____.

Please return this form to UBH/USBHPC: Toll-free fax: 1-800-864-8120

Mail: UBH/USBHPC, ATTN: BHS-Wellness Assessment
PO Box 601520
San Diego, California 92160-1520

Note: Blank copies of this form may be photocopied for use with other clients.