

**ASSESS: MENTAL HEALTH ASSESSMENT**[Back](#)**Wellbeing Assessment**

Child Name [REDACTED]

Questions:

1. Has the child completed a mental health assessment or evaluation in the past 6 months?

- Yes
- No
- Not applicable at this time.

2. Has counseling/therapy been recommended for this youth?

- Yes
- No

3. If recommended, is the child currently receiving counseling or therapy services?

- No
- Yes
- Not applicable at this time.

4. If youth has been prescribed medication, does the youth have a primary psychiatrist to monitor medication prescriptions?

- Yes
- No
- Not applicable at this time.

5. Is the child compliant with any mental health prescribed medication?

- Yes
- No
- Not applicable at this time.

6. Has the youth experienced any psychiatric hospitalizations in the past 6 months?

- Yes
- No

7. Does the child have a developmental disability or diagnosis?

Yes

No

8. If the child has a developmental disability or mental health diagnosis, is the child receiving services and/or prescribed treatment?

Yes

No

Not applicable at this time.

9. Is the youth using non-prescribed substances such as drugs or alcohol?

Yes

No

Do not know

10. If the youth has a substance abuse concern, is the youth receiving appropriate treatment and counseling?

Yes

No

Not applicable at this time.

Has all possible been done for child?

Notes

(0 out of 5000)

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