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

ALERT®

Wellness Assessment - Adult

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

Client Last Name ____________, First Name ____________ 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

For questions 1-16, please think about your experience in the past week.

How much did the following problems bother you?	*Not at All*	*A Little*	*Somewhat*	*A Lot*
1. Nervousness or shakiness	○	○	○	○
2. Feeling sad or blue	○	○	○	○
3. Feeling hopeless about the future	○	○	○	○
4. Feeling everything is an effort	○	○	○	○
5. Feeling no interest in things	○	○	○	○
6. Your heart pounding or racing	○	○	○	○
7. Trouble sleeping	○	○	○	○
8. Feeling fearful or afraid	○	○	○	○
9. Difficulty at home	○	○	○	○
10. Difficulty socially	○	○	○	○
11. Difficulty at work or school	○	○	○	○

How much do you agree with the following?	*Strongly Agree*	*Agree*	*Disagree*	*Strongly Disagree*
12. I feel good about myself	○	○	○	○
13. I can deal with my problems	○	○	○	○
14. I am able to accomplish the things I want	○	○	○	○
15. I have friends or family that I can count on for help	○	○	○	○

16. In the past week, approximately how many drinks of alcohol did you have? ____ Drinks

Please answer the following questions only if this is your first time completing this questionnaire.

17. In general, would you say your health is: ○ Excellent ○ Very Good ○ Good ○ Fair ○ Poor
18. Please indicate if you have a serious or chronic medical condition:
    ○ Asthma ○ Diabetes ○ Heart Disease ○ Back Pain or Other Chronic Pain ○ Other Condition
19. In the past 6 months, how many times did you visit a medical doctor? ○ None ○ 1 ○ 2-3 ○ 4-5 ○ 6+
20. In the past month, how many days were you unable to work because of your physical or mental health? *(answer only if employed)* ____ Days
21. 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 physical or mental health? *(answer only if employed)* ____ Days
22. In the past month have you ever felt you ought to cut down on your drinking or drug use? ○ Yes ○ No
23. In the past month have you ever felt annoyed by people criticizing your drinking or drug use? ○ Yes ○ No
24. In the past month have you felt bad or guilty about your drinking or drug use? ○ Yes ○ No

Spectrum Falls Counseling 2730 S Val Vista Dr. Suite 135 Gilbert, AZ 85295 (480)699-2116

THIS IS NOT A REQUEST FOR INFORMATION

AUTHORIZATION TO RELEASE/EXCHANGE INFORMATION

I, (name of patient) ____, with a date of birth of ______________________ (hereinafter "Patient") hereby authorize **Linda Poure, LCSW, PLC,** (hereinafter "Provider") to disclose/exchange mental health treatment information and records obtained in the course of psychotherapy treatment of Patient including, but not limited to HIPAA Protected Health Information (PHI), with/to: (Primary Care Physician name, address, fax , phone): ____
____

I understand that the information to be released includes records in any form, and oral conversations with the Provider. I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to refuse to sign this authorization. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. And, I also understand that such revocation must be in writing and received by Provider at **2730 S.Val Vista Dr. #7-135 Gilbert, AZ 85295** to be effective.

This disclosure of information and records authorized by Patient is required for the following purpose:

- o Coordination of treatment with another mental health professional involved in your care.
- o Coordination of treatment with another type of health professional involved in your care.
- o To obtain insurance or other third party benefits under a managed care agreement.
- o Coordination with another type of professional (e.g., attorney).
- o To obtain benefits of programs that are not health insurance related (e.g., SSI, SSD, private disability, etc.).

- o Other____

Such disclosure of written or oral conversations shall be limited to the following specific types of information:

- o Assessment, diagnosis, treatment plan, compliance, functionality, test results, and response to treatment.
- o Information pertaining to substance abuse or substance dependency.
- o Sensitive relationship issues, family dynamics, sexual issues, and other highly personal information. ***This information is contained in Psychotherapy Notes as defined by HIPAA. Authorization to release Psychotherapy Notes can not be combined with a release for other PHI on the same form.***

- o Other____

The specific uses of Protected Health Information (PHI) to be discussed or released are as follows:

- o Coordination of response to psychotropic medications prescribed by a psychiatrist or other physician.
- o Coordination of other medical treatment with mental health, marital, or family treatment.
- o Coordination of marital or family treatment with individual treatment.
- o Case management and/or utilization review under a managed care agreement.
- o Review of treatment and/or functionality to obtain benefits of non-health-insurance related programs.

- o Other____

Patient understands that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable Arizona law may protect such information.

This authorization shall remain valid until: _______________________________________

Patient's signature: ____ Date: ____________________

Witness (if necessary): ____ Date: ____________________