

The following data collection form was developed by Dr. Susan Wagner of Data Driven Enterprises in collaboration with UPLIFT, Wyoming's Federation of Families for Children's Mental Health and Statewide Family Network ([www.upliftwy.org](http://www.upliftwy.org)).

Questions were developed to collect required information and data based on current contracts in addition to paralleling the State of Wyoming Mental Health Statistics Improvement Program (MHSIP) Consumer Survey for consumers and family members accessing services at Community Mental Health Centers.

***Family and Youth Skill Assessment at Intake*** forms are to be completed by families and youth (14 years or older) at the time of intake or at the beginning of your organization's service program. ***Family and Youth Feedback*** forms are to be completed by families and youth (14 years or older) every six months or at case closure. The feedback responses can be matched and compared to the responses at intake to show program outcomes.

This sample form is shared with permission and your organization may customize it to meet your specific data needs.

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Please provide us with the following information. We will use this information to improve services for your family.

### A. BACKGROUND INFORMATION

Child's First Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_

1. What is your relationship to the child:  Parent  Relative  Foster Parent  Other \_\_\_\_\_
2. What is your gender:  Male  Female
3. What is the child's age range?
  - 0-4 years  5-8 years  9-12 years  13-15 years  16-18 years  19+ years
4. Please indicate the type of disability/disorder the child has (*check all that apply*):
  - Emotional  Developmental  Physical  Learning  Other \_\_\_\_\_
5. What is the child's current living situation?
  - Parent/Guardian Home  Relative Home  Foster Care  Treatment Facility  Other \_\_\_\_\_
6. Is the child currently in state custody?  Yes  No
7. Where is the child currently receiving services (*check all that apply*):
  - School  Family Doctor/Pediatrician  Dentist
  - Private Counselor  Community Mental Health Center  Department of Family Services
  - Substance Abuse  Other \_\_\_\_\_
8. Where are you and/or your family currently receiving services (*check all that apply*):
  - School  Family Doctor/Pediatrician  Dentist
  - Private Counselor  Community Mental Health Center  Department of Family Services
  - Substance Abuse  Other \_\_\_\_\_

### B. CHILD BEHAVIOR

For each of the following skill areas, indicate your level of agreement.

Skill Area	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. The child has a network of friends (his/her own age) ....	1	2	3	4	5
2. The child interacts appropriately with others.....	1	2	3	4	5
3. The child gets along with family members.....	1	2	3	4	5
4. The child is able to cope when things go wrong.....	1	2	3	4	5
5. The child is able to express feelings in an appropriate way .....	1	2	3	4	5
6. The child demonstrates effective decision-making skills.....	1	2	3	4	5
7. The child has control of his or her behavior .....	1	2	3	4	5
8. The child follows rules .....	1	2	3	4	5
9. The child is doing well in school and/or work .....	1	2	3	4	5
10. The child regularly participates in positive activities outside of school .....	1	2	3	4	5

### C. FAMILY SKILLS

*For each of the following skill areas, indicate your level of agreement.*

Skill Area	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. My family effectively communicates with each other ...	1	2	3	4	5
2. My family is able to cope when things go wrong .....	1	2	3	4	5
3. My family is able to understand the child's needs .....	1	2	3	4	5
4. My family advocates for the child.....	1	2	3	4	5
5. My family regularly plans/participates in activities together .....	1	2	3	4	5
6. My family is able to access the services we need .....	1	2	3	4	5
7. My family receives the needed supports to keep the child at home .....	1	2	3	4	5

### D. FAMILY STRESS

*For each of the following stress areas, indicate your family's current level of stress.*

How would you rate:	Not at all	A little	Somewhat	Quite a bit	Very much
1. How tired or strained do you feel as a result of the child's situation? .....	1	2	3	4	5
2. In general, how much of a toll has the child's situation taken on your family? .....	1	2	3	4	5