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# Daily Well-Check

## Patient # Volunteer# Date: Time:

### In general, how do you feel today?

🞎 Confident 🞎 Happy 🞎 Sad 🞎 Scared 🞎 Guilty 🞎 OK

Comments:

### Do you have any new medical complaints?

🞎 Yes 🞎 No

Comments:

### Since we last spoke, have you felt sad or depressed?

🞎 Yes 🞎 No

Comments:

### Have you thought about hurting yourself or other people?

🞎 Yes 🞎 No

Comments:

### Since we last spoke, have you felt angry, frustrated, or experienced a panic attack?

🞎 Yes 🞎 No

Comments:

### Have you physically or verbally acted out against a friend or family member?

🞎 Yes 🞎 No

Comments:

### Since we last spoke, have you missed any school?

🞎 Yes 🞎 No

Comments:

### Are you behind in any of your classes?

🞎 Yes 🞎 No

Comments:

### Since we last spoke, have you been participating in (insert activities of preference) I.e. sports, exercise, social clubs etc?

🞎 Yes 🞎 No

Comments:

### Have you had any recent trouble sleeping or noticed a decrease in your appetite?

🞎 Yes 🞎 No

Comments:

### Since we last spoke, have you witnessed or been sent hateful messages via text, email, or social media

🞎 Yes, Witnessed 🞎 Yes, Victim 🞎 Yes, Both 🞎 No

Comments:

### How did you react to the messaging?

🞎 Ignored it 🞎 Reported it 🞎 Confronted the sender 🞎 Blocked the Sender

Comments:

### Since we last spoke, have you used any alcohol or marijuana?

🞎 Yes 🞎 No

Comments:

Is there any information or services we can help provide you with?

🞎 Counseling 🞎 Social Media Support 🞎 Community Service

🞎 Mental Health 🞎 School Support 🞎 other

Comments:

### Are you supposed to be involved in any extracurricular activities in the near future?

🞎 Yes 🞎 No

Comments:

### Have you been communicating with your emergency contacts, family, or support network?

🞎 Yes 🞎 No

Comments:

### Do you feel like you have enough support from your friends, school, or family to deal with bullying?

🞎 Yes, 🞎 No

Comments:

### Can I call you tomorrow or on our regularly scheduled day at our normal time?

🞎 Yes | 🞎 No

Comments:

**OPTIONAL Questions for participants with mental health concerns**

### Have you been taking your medications and following your doctor’s recommendations?

🞎 Yes 🞎 No

Comments:

### How do you feel about your current medication regimen and medical guidance?

🞎 Good 🞎 No Opinion 🞎 Poor 🞎 Other

Comments:

## Volunteer notes:

Was there anything unusual about the participant? 🞎 Yes | 🞎 No

Was there anything that concerned you about the participant? 🞎 Yes | 🞎 No

If ***yes***, to either question call emergency contact, primary care provider, or emergency medical services

Who did you call?

What time did you call?

Did they answer?

What is the plan to check patient?

## Additional Feedback: Please list any other information that you would like us to have:

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