

# Healthy Kids

## MENTAL HEALTH WELLNESS QUESTIONNAIRE

Child's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Managed Care Organization: \_\_\_\_\_ Child's Medicaid #: \_\_\_\_\_

Ages 3 - 5

*Check all answers that may apply. This form may be filled out by the parent/guardian or health care provider.*

Does your child often wet or soil his pants? .....  Yes  No

Does your child have problems at day care or school? .....  Yes  No

Do you have any concerns about your child:

Daydreaming .....  Yes  No

Paying attention .....  Yes  No

Sitting still .....  Yes  No

Does your child :

Refuse to obey .....  Yes  No

Refuse to play with others .....  Yes  No

Does your child get tired easily? .....  Yes  No

Does your child often seem:

Sad .....  Yes  No

Angry .....  Yes  No

Nervous or afraid .....  Yes  No

Cranky .....  Yes  No

Not interested .....  Yes  No

Does your child have trouble sleeping? .....  Yes  No

Does your child have problems with eating? .....  Yes  No

Is your child often mean to animals or smaller children? .....  Yes  No

*(Continued on back)*

MARYLAND HEALTHY KIDS PROGRAM

*Maryland Department of Health and Mental Hygiene*

*Medical Care Policy Administration, Division of Children's Services*

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Is there a history of injuries, accidents? .....  Yes  No  
If yes, please specify: \_\_\_\_\_

Is there any history of maltreatment or abuse? .....  Yes  No  
If yes, please specify: \_\_\_\_\_

Is there a recent stress on the family or child such as :

- |                                 |                              |                             |
|---------------------------------|------------------------------|-----------------------------|
| Birth of a child .....          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Moving .....                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Divorce or separation .....     | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Death of a close relative ..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Fired or laid off .....         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Legal problems .....            | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Others (Please specify): _____  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Do you have other parenting concerns? .....  Yes  No  
Please specify: \_\_\_\_\_

Provider: Give details of all Positive findings.

\_\_\_\_\_  
Provider's Signature  
Provider's Phone: (\_\_\_\_\_) / \_\_\_\_ / \_\_\_\_

\_\_\_\_\_  
Date

## ***THIS FORM MAY BE USED FOR MENTAL HEALTH REFERRALS***

Child Receiving Referral: \_\_\_\_\_

Child's Address: \_\_\_\_\_

Child's Phone: \_\_\_\_\_

Referred to: \_\_\_\_\_

Reason for Referral: \_\_\_\_\_

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