

Healthy Kids

MENTAL HEALTH WELLNESS QUESTIONNAIRE

Child's Name: _____
Managed Care Organization: _____

Date of Birth: _____
Child's Medicaid #: _____

Ages 6 - 9

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

Does your child often seem:

- | | | |
|-------------------------------------|------------------------------|-----------------------------|
| Distrustful of others | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have trouble paying attention | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Blame others | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Do you have concerns about your child's:

- | | | |
|--------------|------------------------------|-----------------------------|
| Eating | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Sleep | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Weight | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Does your child often complain of "not feeling well"?

Yes No

Does your child have problems getting along with:

- | | | |
|---------------------------|------------------------------|-----------------------------|
| Parent(s) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Other family members..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Friends | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| School mates | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Does your child have problems at school with:

- | | | |
|-----------------------------------|------------------------------|-----------------------------|
| Behavior | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Grades | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Not wanting to go to school | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Does your child often seem:

- | | | |
|-------------------------|------------------------------|-----------------------------|
| Sad | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Angry | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Nervous or afraid | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cranky | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Not interested | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Does your child often:

- | | | |
|--|------------------------------|-----------------------------|
| Destroy property | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Lie | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Steal | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hurt animals or smaller children | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

(Continued on back)

MARYLAND HEALTHY KIDS PROGRAM

*Maryland Department of Health and Mental Hygiene
Medical Care Policy Administration, Division of Children's Services*

Healthy Kids

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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