

MENTAL HEALTH QUESTIONNAIRE

Maryland Healthy Kids Program

Date _____

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

Ages 10 – 12 years

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

Does your child have trouble paying attention? Yes No

Does your child often seem:

 Distrustful of others? Yes No

 To express strange thoughts? Yes No

 Blame others? Yes No

Does your child have problems at school with:

 Behavior? Yes No

 Grades? Yes No

 Skipping classes? Yes No

Do you have concerns about your child's:

 Eating? Yes No

 Sleep? Yes No

 Weight? Yes No

Does your child often complain of "not feeling well"? Yes No

Does your child have trouble making or keeping friends? Yes No

Does your child often seem:

 Sad? Yes No

 Angry? Yes No

 Nervous or afraid? Yes No

Does your child show any of these behaviors?

 Destroy property? Yes No

 Set fire? Yes No

 Lie? Yes No

 Steal? Yes No

 Listen to music with violent message? Yes No

 Hurt animal or smaller children? Yes No

 Use alcohol? Yes No

 Use drugs? Yes No

 Smoke cigarettes? Yes No

 Sexually active? Yes No

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MARYLAND HEALTHY KIDS PROGRAM

Maryland Department of Health and Mental Hygiene
HealthChoice and Acute Care Administration, Division of Healthy Kids

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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 Yes No

Moving Yes No

Divorce or separation Yes No

Death of a close relative Yes No

Fired or laid off Yes No

Legal problems Yes No

Others (Please specify): _____

Do you have other parenting concerns? Yes No

Please specify: _____

Provider: Give details of all Positive findings.

Provider's Signature

Date

Provider's Phone: (_____) / ____ / ____

THIS FORM MAY BE USED FOR MENTAL HEALTH REFERRALS

Child Receiving Referral: _____

Child's Address: _____

Child's Phone: _____

Referred to: **Maryland Public Mental Health System: 1-800-888-1965**

Reason for Referral: _____

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