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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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: ________________________________________________

MARYLAND HEALTHY KIDS PROGRAM
Maryland Department of Health and Mental Hygiene HealthChoice and
Acute Care Administration, Division of Children’s Services

https://mmcp.dhmh.maryland.gov/epsdt

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