MENTAL HEALTH QUESTIONNAIRE
Maryland Healthy Kids Program
Date_________

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

Child’s Name: ___________________________________________ Date of Birth: __________________________
Managed Care Organization: ___________________________ Child’s Medicaid #: ＿＿＿＿＿＿

Ages 3 – 5 years

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

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

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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: MD Public Mental Health System: 1-800-888-1965
Reason for Referral: _____________________________________________

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