MENTAL HEALTH QUESTIONNAIRE
Maryland Healthy Kids Program

Date __________

Child’s Name: ___________________________ Date of Birth: __________

Managed Care Organization: ___________________ Child’s Medicaid #: __________

Ages 6 – 9 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 seem:
- Distrustful of others? ................................................................. ☐ Yes ☐ No
- Have trouble paying attention? ................................................... ☐ Yes ☐ No
- Blame others? ................................................................. ☐ 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 problems getting along with:
- Parent(s)? ................................................................. ☐ Yes ☐ No
- Other family members? ................................................... ☐ Yes ☐ No
- Friends? ................................................................. ☐ Yes ☐ No
- School mates? ................................................................. ☐ Yes ☐ No

Does your child have problems at school with:
- Behavior? ................................................................. ☐ Yes ☐ No
- Grades? ................................................................. ☐ Yes ☐ No
- Not wanting to go to school? ................................................................. ☐ 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 often:
- Destroy property? ................................................................. ☐ Yes ☐ No
- Lie? ................................................................. ☐ Yes ☐ No
- Steal? ................................................................. ☐ Yes ☐ No
- Hurt animals or smaller children? ................................................................. ☐ Yes ☐ No

Continued on back →
MENTAL HEALTH QUESTIONNAIRE
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Date__________

Page Two

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 2014