

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

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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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