

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

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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?.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Moving?.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Divorce or separation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Death of a close relative?.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fired or laid off?.....	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Legal problems?.....	<input type="checkbox"/> Yes	<input type="checkbox"/> 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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