

# 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 HEALTHY KIDS PROGRAM  
Maryland Department of Health and Mental Hygiene  
HealthChoice and Acute Care Administration, Division of Healthy Kids

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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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