

MENTAL HEALTH QUESTIONNAIRE

Maryland Healthy Kids Program

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 behavior:
- 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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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): _____ Yes No

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: _____

Reason for Referral: _____