

MENTAL HEALTH QUESTIONNAIRE

Maryland Healthy Kids Program

Child's Name: _____ Date of Birth: _____
Managed Care Organization: _____ Child's Medicaid #: _____

Ages 3 – 5 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 wet or soil his pants? Yes No

Does your child have problems at day care or school? Yes No

Do you have any concerns about your child:

Daydreaming Yes No

Paying attention Yes No

Sitting still Yes No

Does your child:

Refuse to obey Yes No

Refuse to play with others Yes No

Does your child get tired easily? 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 have trouble sleeping? Yes No

Does your child have problems with eating? Yes No

Is your child often mean to animals or smaller children? Yes No

(Continued on back)

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Maryland Healthy Kids Program

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): _____ 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: _____
