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 heal 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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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: _____

_____