MENTAL HEALTH QUESTIONNAIRE
Maryland Healthy Kids Program
Date_____

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 heal 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 behaviors?		
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): _____

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: _____