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

(Continued on back)

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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: _____

_____