MENTAL HEALTH QUESTIONNAIRE
Maryland Healthy Kids Program

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

Ages 13 – 20 years

Check all answers that may apply. This form may be filled out by the patient, parent/guardian or health care provider.

Do you have trouble paying attention?	☐ Yes	☐ No
Do you often:		
Feel distrustful of others	☐ Yes	☐ No
Have strange thoughts	☐ Yes	☐ No
Hear voices	☐ Yes	☐ No
Have to do things the same way or keep repeating them	☐ Yes	☐ No
Do you have problems at school with:		
Behavior	☐ Yes	☐ No
Grades	☐ Yes	☐ No
Skipping classes	☐ Yes	☐ No
Do you worry about your:		
Eating	☐ Yes	☐ No
Sleep	☐ Yes	☐ No
Weight	☐ Yes	☐ No
Do you have trouble making or keeping friends?	☐ Yes	☐ No
Do you often feel:		
Sad	☐ Yes	☐ No
Angry	☐ Yes	☐ No
Nervous or afraid	☐ Yes	☐ No
Have you thought about or done any of the following:		
Destroy property	☐ Yes	☐ No
Hurt animals	☐ Yes	☐ No
Set fire	☐ Yes	☐ No
Listen to music with violent message	☐ Yes	☐ No
Use alcohol	☐ Yes	☐ No
Use drugs	☐ Yes	☐ No
Smoke cigarettes	☐ Yes	☐ No
Sex without protection	☐ Yes	☐ No
Suicide attempt	☐ 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: _____

_____