MENTAL HEALTH QUESTIONNAIRE
Maryland Healthy Kids Program

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 health 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): _____ ☐ 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: _____