MENTAL HEALTH QUESTIONNAIRE

Maryland Healthy Kids Program

Date_____

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): _____

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: _____
_____