MENTAL HEALTH QUESTIONNAIRE

Maryland Healthy Kids Program

Date_____

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

Ages 3 – 5 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 wet or soil his pants? ☐ Yes ☐ No

Does your child have problems at day care or school? ☐ Yes ☐ No

Do you have any concerns about your child:
- Daydreaming? ☐ Yes ☐ No
- Paying attention? ☐ Yes ☐ No
- Sitting still? ☐ Yes ☐ No

Does your child:
- Refuse to obey? ☐ Yes ☐ No
- Refuse to play with others? ☐ Yes ☐ No

Does your child get tired easily? ☐ 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 have trouble sleeping? ☐ Yes ☐ No

Does your child have problems with eating? ☐ Yes ☐ No

Is your child often mean to animals or smaller children? ☐ Yes ☐ No

Is there a history of injuries, accidents? ☐ Yes ☐ No
If yes, please specify: _____

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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: **MD Public Mental Health System: 1-800-888-1965**
Reason for Referral: _____
_____