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: ____

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