

# Maryland Healthy Kids Program Medical/Family History Questionnaire

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| Patient Name: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                    | Date of Birth: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | Sex: (circle)<br>Male    Female |
| Form Completed By: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | Today's Date _____ | Relationship: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |                                 |
| <b>PREGNANCY AND BIRTH HISTORY</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                    | <b>PSYCHOSOCIAL HISTORY</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                 |
| Name of Hospital: _____<br>Illnesses during pregnancy?    No <input type="checkbox"/> Yes <input type="checkbox"/><br>Medications during pregnancy?    No <input type="checkbox"/> Yes <input type="checkbox"/><br>Alcohol/Drug Abuse?    No <input type="checkbox"/> Yes <input type="checkbox"/><br>Problems at birth?    No <input type="checkbox"/> Yes <input type="checkbox"/><br>Describe: _____<br>Type of delivery? <input type="checkbox"/> Vaginal <input type="checkbox"/> C-section<br>Birth Weight _____ Discharge Weight _____<br>Did baby receive Hepatitis B vaccine?    No <input type="checkbox"/> Yes <input type="checkbox"/><br>Date of Hepatitis B immunization: _____<br>Newborn Hearing Screen?    No <input type="checkbox"/> Yes <input type="checkbox"/>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                    | Who lives in household? _____<br>How many? _____<br><input type="checkbox"/> Rent? <input type="checkbox"/> Own? <input type="checkbox"/> Shelter?<br>Who cares for child? _____<br>Date of Birth?    Mother _____<br>Father _____<br>Are parents working?    Mother    No <input type="checkbox"/> Yes <input type="checkbox"/><br>Father    No <input type="checkbox"/> Yes <input type="checkbox"/><br>Foster Care?    _____    Dates: _____<br>Other Languages? _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |                                 |
| <b>FAMILY HISTORY</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                    | <b>MEDICAL HISTORY</b>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |                                 |
| Has anyone in the family (parents, grand-parents, aunts/uncles, sisters/brothers) had:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                    | Has your child ever had:                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |                                 |
| Allergies (List) _____    No <input type="checkbox"/> Yes <input type="checkbox"/> Who? _____<br>Asthma    No <input type="checkbox"/> Yes <input type="checkbox"/> _____<br>TB/Lung Disease    No <input type="checkbox"/> Yes <input type="checkbox"/> _____<br>HIV/AIDS    No <input type="checkbox"/> Yes <input type="checkbox"/> _____<br>Suicide Attempts    No <input type="checkbox"/> Yes <input type="checkbox"/> _____<br>Heart Disease    No <input type="checkbox"/> Yes <input type="checkbox"/> _____<br>High Blood Pressure/Stroke    No <input type="checkbox"/> Yes <input type="checkbox"/> _____<br>High Cholesterol    No <input type="checkbox"/> Yes <input type="checkbox"/> _____<br>Blood Disorders/Sickle Cell    No <input type="checkbox"/> Yes <input type="checkbox"/> _____<br>Diabetes    No <input type="checkbox"/> Yes <input type="checkbox"/> _____<br>Seizures    No <input type="checkbox"/> Yes <input type="checkbox"/> _____<br>Mental Illness    No <input type="checkbox"/> Yes <input type="checkbox"/> _____<br>Cancer    No <input type="checkbox"/> Yes <input type="checkbox"/> _____<br>Birth Defects    No <input type="checkbox"/> Yes <input type="checkbox"/> _____<br>Hearing Loss    No <input type="checkbox"/> Yes <input type="checkbox"/> _____<br>Speech Problems    No <input type="checkbox"/> Yes <input type="checkbox"/> _____<br>Kidney Disease    No <input type="checkbox"/> Yes <input type="checkbox"/> _____<br>Alcohol/Drug Abuse    No <input type="checkbox"/> Yes <input type="checkbox"/> _____<br>Hepatitis/Liver Disease    No <input type="checkbox"/> Yes <input type="checkbox"/> _____<br>Thyroid Disease    No <input type="checkbox"/> Yes <input type="checkbox"/> _____<br>Learning Problems/Attention Deficit Disorder    No <input type="checkbox"/> Yes <input type="checkbox"/> _____<br>Family Violence    No <input type="checkbox"/> Yes <input type="checkbox"/> _____<br><br>Other: _____ |                    | Allergies (List) _____    No <input type="checkbox"/> Yes <input type="checkbox"/><br>Asthma    No <input type="checkbox"/> Yes <input type="checkbox"/><br>Chicken Pox (Year) _____    No <input type="checkbox"/> Yes <input type="checkbox"/><br>Frequent Ear Infections    No <input type="checkbox"/> Yes <input type="checkbox"/><br>Vision/Hearing Problems    No <input type="checkbox"/> Yes <input type="checkbox"/><br>Skin Problems/Eczema    No <input type="checkbox"/> Yes <input type="checkbox"/><br>TB/Lung Disease    No <input type="checkbox"/> Yes <input type="checkbox"/><br>Seizures/Epilepsy    No <input type="checkbox"/> Yes <input type="checkbox"/><br>High Blood Pressure    No <input type="checkbox"/> Yes <input type="checkbox"/><br>Heart Defects/Disease    No <input type="checkbox"/> Yes <input type="checkbox"/><br>Liver Disease/Hepatitis    No <input type="checkbox"/> Yes <input type="checkbox"/><br>Diabetes    No <input type="checkbox"/> Yes <input type="checkbox"/><br>Kidney Disease/Bladder Infections    No <input type="checkbox"/> Yes <input type="checkbox"/><br>Physical or Learning Disabilities    No <input type="checkbox"/> Yes <input type="checkbox"/><br>Bleeding Disorders/Hemophilia    No <input type="checkbox"/> Yes <input type="checkbox"/><br>Sexually Transmitted Diseases    No <input type="checkbox"/> Yes <input type="checkbox"/><br>Emotional or Behavioral Problems    No <input type="checkbox"/> Yes <input type="checkbox"/><br>Depression/Suicidal Thoughts    No <input type="checkbox"/> Yes <input type="checkbox"/><br>Hospitalizations/Surgeries    No <input type="checkbox"/> Yes <input type="checkbox"/><br>Physical/Emotional/ Sexual Abuse    No <input type="checkbox"/> Yes <input type="checkbox"/><br>Bone or Joint Injuries    No <input type="checkbox"/> Yes <input type="checkbox"/><br>Obesity/Eating Disorders    No <input type="checkbox"/> Yes <input type="checkbox"/><br>Other: _____    No <input type="checkbox"/> Yes <input type="checkbox"/><br><br>Current Medication(s): (List) _____ |                                 |
| Reviewed by: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                    | Date of Review: _____                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                 |

**NUTRITION QUESTIONNAIRE FOR CHILDREN AGES 1 TO 10**

1. How would you describe your child's appetite?

- Fair
- Good
- Poor

2. How many days per week does your family eat meals together?

3. How would you describe mealtimes with your child?

- Always pleasant
- Usually pleasant
- Sometimes pleasant
- Never pleasant

4. How many meals does your child eat per day? How many snacks?

5. Which of these foods did your child eat or drink last week?  
(Check all that apply)

**Grains:**

- Bagels
- Bread
- Cereal/grits
- Crackers
- Muffins
- Noodles/pasta/rice
- Rolls
- Tortillas
- Other grains:.....

**Vegetables**

- Broccoli
- Carrots
- Corn
- Green beans
- Green salad
- Greens (collard, spinach)
- Peas
- Potatoes
- Tomatoes
- Other vegetables.....

**Fruits**

- Apples/ juice
- Bananas
- Grapefruit/juice
- Grapes/juice
- Melon
- Oranges/juice
- Peaches
- Pears
- Other fruits/ juice:.....

**Milk and Milk Products**

- Fat-free (skim) milk
- Low-fat (1%) milk
- Reduced-fat (2%) milk
- Whole milk
- Flavored milk
- Cheese
- Ice cream
- Yogurt
- Other milk and milk products: .....

**Meal and Meal Alternatives**

- Beef/hamburger
- Chicken
- Cold cuts/ deli meals
- Dried beans (for example, black beans, kidney beans, pinto beans)
- Eggs
- Fish
- Peanut butter/nuts
- Pork
- Sausage/bacon
- Tofu
- Turkey
- Other meal and meat alternatives:.....

**Fats and Sweets**

- Cake/cupcakes
- Candy
- Chips
- French fries
- Cookies
- Doughnuts
- Fruit-flavored drinks
- Soft drinks
- Pies
- Other fats and sweets: .....

NUTRITION QUESTIONNAIRE FOR CHILDREN AGES 1 TO 10

6. If your child is 5 years or younger, does he or she eat any of these foods? (Check all that apply.)
- Hot dogs
  - Marshmallows
  - Nuts and seeds
  - Peanut butter
  - Popcorn
  - Pretzels and chips
  - Raisins
  - Raw celery or carrots
  - Hard or chewy candy
  - Whole grapes
7. How much juice does your child drink per day? How much sweetened beverage (for example, fruit punch or soft drinks) does your child drink per day?
8. Does your child take a bottle to bed at night or carry a bottle around during the day?
- Yes       No
9. What is the source of the water your child drinks? Sources include public, well, commercially bottled, and home system-processed water?
10. Do you have a working stove, oven, and refrigerator where you live?
- Yes       No
11. Were there any days last month when your family didn't have enough food to eat or enough money to buy food?
12. Did you participate in physical activity (for example, walking or riding a bike) in the past week?
- Yes       No
- If yes, on how many days and for how many minutes or hours per day?.....
13. Does your child spend more than 2 hours per day watching television and DVDs or playing computer games:
- Yes       No
- If yes, how many hours per day?.....
14. Does your family watch television during meals?
- Yes       No
15. What concerns or questions do you have about feeding your child or how your child is growing? Do you have any concerns or questions about your child's weight?

# MARYLAND HEALTHY KIDS PROGRAM

## Preventive Screen Questionnaire

**Lead Risk Assessment:**  
(every well child visit from 6 months up to 6 years)

- |                                                                                                                                                                                                                                                                                                                                                                                                         | Date  | Date  | Date  | Date  | Date  | Date  | Date  | Date  | Date  |
|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 1. Has your child ever lived or stayed in a house or apartment that is built before 1978 (includes day care center, preschool home, home of babysitter or relative)?                                                                                                                                                                                                                                    | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N |
| 2. Has your child ever lived outside the United States or recently arrived from a foreign country?                                                                                                                                                                                                                                                                                                      | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N |
| 3. Is anyone in the home being treated or followed for lead poisoning?                                                                                                                                                                                                                                                                                                                                  | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N |
| 4. Are there any current renovations or peeling paint in a home that your child regularly visits?                                                                                                                                                                                                                                                                                                       | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N |
| 5. Does your child lick, eat, or chew things that are not food (paint chips, dirt, railings, poles, furniture, old toys, etc.)?                                                                                                                                                                                                                                                                         | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N |
| 6. Is there any family member who is currently working in an occupation or hobby where lead exposure could occur (auto mechanic, ceramics, commercial painter, etc.)?                                                                                                                                                                                                                                   | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N |
| 7. Does your family use products from other countries such as health remedies, traditional remedies, spices, cosmetics or other products canned or packaged outside of the United States? Or store or serve food in leaded crystal, pottery or pewter?<br>Examples: Glazed pottery, Greta, Azarcon (Ruenda, Coral, Liga), Litargirio, Surma, Kohl (Al kohl), Pay-lou-ah, Ayurvedic medicine, Ghassard). | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N |

**Tuberculosis Risk Assessment:**

(The assessment must be completed at 1, 6 and 12 months, and then annually starting at 36 months.)

- |                                                                                                                                                                                          | Date  | Date  | Date  | Date  | Date  | Date  | Date  | Date  | Date  |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 1. Has your child been exposed to anyone with a case of TB <u>or</u> a positive tuberculin skin test, <u>or</u> received a tuberculosis vaccination?                                     | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N |
| 2. Was your child, or a household member, born in a high-risk country (countries other than the United States, Canada, Australia, New Zealand, or Western and North European countries)? | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N |
| 3. Has your child travelled (had a contact with resident populations) to a high-risk country for more than 1 week?                                                                       | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N |
| 4. Does your child have daily contact with adults at high risk for TB (e.g., those who are HIV infected, homeless, incarcerated, and/or illicit drug users)?                             | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N |
| 5. Does your child have HIV infection?                                                                                                                                                   | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N |

(A "yes" response or "don't know" to any question indicates a positive risk)

Patient Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_

<https://mmco.dhnh.maryland.gov/epsdt/Pages/Home.aspx>

# MARYLAND HEALTHY KIDS PROGRAM

## Preventive Screen Questionnaire

**Anemia Screening**  
(Starting at 11 years of age and annually thereafter)

1. (FEMALES AND MALES) Does the child/adolescent's diet include iron-rich foods such as meat, eggs, iron-fortified cereals, or beans?

| Date  | Date  | Date  | Date  | Date  | Date  | Date  | Date  | Date  | Date  |
|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N |

2. (FEMALES AND MALES) Have you ever been diagnosed with iron deficiency anemia?

|       |       |       |       |       |       |       |       |       |       |
|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N |
|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|

3. (FEMALES ONLY) Do you have excessive menstrual bleeding or other blood loss?

|       |       |       |       |       |       |       |       |       |       |
|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N |
|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|

4. (FEMALES ONLY) Does your period last more than 5 days?

|       |       |       |       |       |       |       |       |       |       |
|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N |
|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|

**Heart Disease/Cholesterol Risk Assessment:**  
(2 years through 20 years)

1. Is there a family history of parents/grandparents under 55 years of age with a heart attack, heart surgery, angina or sudden cardiac death?

|       |       |       |       |       |       |       |       |       |       |
|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N |
|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|

2. Has the child's mother or father been diagnosed with high cholesterol (240 mg/dL or higher)?

|       |       |       |       |       |       |       |       |       |       |
|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N |
|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|

3. Is the child/adolescent overweight (BMI > 85<sup>th</sup> %)?

|       |       |       |       |       |       |       |       |       |       |
|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N |
|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|

4. And is there a personal history of:

|                            |       |       |       |       |       |       |       |       |       |
|----------------------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| Smoking?                   | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N |
| Lack of physical activity? | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N |
| High blood pressure?       | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N |
| High cholesterol?          | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N |
| Diabetes mellitus?         | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N |

*(Refer to the AAP Clinical Guidelines for Childhood Lipid Screening)*

**STI/HIV Risk Assessment:**  
(11 years through 20 years)

|                                                                                                |       |       |       |       |       |       |       |       |       |
|------------------------------------------------------------------------------------------------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| 1. Are you sexually active?                                                                    | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N |
| 2. If sexually active, have you had more than one partner?                                     | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N |
| 3. If sexually active, have you had unprotected sex, with opposite/same sex?                   | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N |
| 4. Have you ever been sexually molested or physically attacked?                                | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N |
| 5. Have you ever been diagnosed with any sexually transmitted diseases?                        | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N |
| 6. Any body tattoos or body piercing of ears, navel, etc., including any performed by friends? | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N |
| 7. Have you had a blood transfusion or are you a Hemophiliac?                                  | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N |
| 8. Any history of IV drug use by you, your sex partner, or your birth mother during pregnancy? | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N | Y / N |

A "yes" response or "don't know" to any question indicates a positive risk

Patient Name: \_\_\_\_\_

Birth Date: \_\_\_\_\_

# MENTAL HEALTH QUESTIONNAIRE

## Maryland Healthy Kids Program

Date \_\_\_\_\_

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

Continued on back →

MARYLAND HEALTHY KIDS PROGRAM  
Maryland Department of Health and Mental Hygiene  
HealthChoice and Acute Care Administration, Division of Children's Services

# MENTAL HEALTH QUESTIONNAIRE

## Maryland Healthy Kids Program

Date \_\_\_\_\_

Page Two

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?.....          | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Moving?.....                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Divorce or separation? .....    | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Death of a close relative?..... | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Fired or laid off?.....         | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Legal problems?.....            | <input type="checkbox"/> Yes | <input type="checkbox"/> 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: (\_\_\_\_\_) / \_\_\_\_ / \_\_\_\_\_

|                                                                          |
|--------------------------------------------------------------------------|
| <b><i>THIS FORM MAY BE USED FOR MENTAL HEALTH REFERRALS</i></b>          |
| Child Receiving Referral: _____                                          |
| Child's Address: _____                                                   |
| Child's Phone: _____                                                     |
| Referred to: <b>Maryland Public Mental Health System: 1-800-888-1965</b> |
| Reason for Referral: _____                                               |
| _____                                                                    |

**MARYLAND HEALTHY KIDS PROGRAM**  
Maryland Department of Health and Mental Hygiene  
HealthChoice and Acute Care Administration, Division of Children's Services