MENTAL HEALTH QUESTIONNAIRE

Maryland Healthy Kids Program

Date_____

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

Ages 10 – 12 years

Check all answers that may apply. This form may be filled out by the parent/guardian or health care provider.

Does your child have trouble paying attention?	☐ Yes	☐ No
Does your child often seem:		
Distrustful of others?	☐ Yes	☐ No
To express strange thoughts?.....	☐ Yes	☐ No
Blame others?	☐ Yes	☐ No
Does your child have problems at school with:		
Behavior?.....	☐ Yes	☐ No
Grades?	☐ Yes	☐ No
Skipping classes?.....	☐ 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 trouble making or keeping friends?	☐ Yes	☐ No
Does your child often seem:		
Sad?	☐ Yes	☐ No
Angry?.....	☐ Yes	☐ No
Nervous or afraid?.....	☐ Yes	☐ No
Does your child show any of these behaviors?		
Destroy property?	☐ Yes	☐ No
Set fire?	☐ Yes	☐ No
Lie?	☐ Yes	☐ No
Steal?	☐ Yes	☐ No
Listen to music with violent message?	☐ Yes	☐ No
Hurt animal or smaller children?	☐ Yes	☐ No
Use alcohol?	☐ Yes	☐ No
Use drugs?.....	☐ Yes	☐ No
Smoke cigarettes?	☐ Yes	☐ No
Sexually active?	☐ Yes	☐ No

Continued on back →

MENTAL HEALTH QUESTIONNAIRE

Maryland Healthy Kids Program

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 …… ☐ 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: _____

_____

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** ____
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
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
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
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
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
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
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? **Examples**: Glazed pottery, Greta, Azarcon (Rueda, Coral, Liga), Litargirio, Surma, Kohl (Al kohl), Pay-loo-ah, Ayurvedic medicine, Ghassard).	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N

Tuberculosis Risk Assessment: *(Starting at 1 month, 6 months of age and annually thereafter)*	**Date** ____	**Date** ____	**Date** ____	**Date** ____	**Date** ____	**Date** ____	**Date** ____
1. Has your child been exposed to anyone with a case of TB **or** a positive tuberculin skin test, **or** received a tuberculosis vaccination?	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
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
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
5. Does your child have HIV infection?	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:** _____

MARYLAND HEALTHY KIDS PROGRAM

Preventive Screen Questionnaire

Anemia Screening (Starting at 11 years of age and annually thereafter)	**Date** ____	**Date** ____	**Date** ____	**Date** ____	**Date** ____	**Date** ____	**Date** ____
1. (FEMALES AND MALES) Does the child/adolescent's diet include iron-rich foods such as meat, eggs, iron-fortified cereals, or beans?	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
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
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
Heart Disease/Cholesterol Risk Assessment: *(2 years through 20 years)*	**Date** ____	**Date** ____	**Date** ____	**Date** ____	**Date** ____	**Date** ____	**Date** ____
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
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
3. Is the child/adolescent overweight (BMI > 85th %)?	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
Lack of physical activity?	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
High cholesterol?	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
(Refer to the AAP Clinical Guidelines for Childhood Lipid Screening)	**Date** ____	**Date** ____	**Date** ____	**Date** ____	**Date** ____	**Date** ____	**Date** ____
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
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
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
4. Have you ever been sexually molested or physically attacked?	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
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
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
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

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

Patient Name: _____ **Birth Date:** _____