

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

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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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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 <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
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 > 85 th %)?	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)

STI/HIV Risk Assessment:

(11 years through 20 years)

	Date	Date	Date	Date	Date	Date	Date
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: _____

A Survey From Your Healthcare Provider — PHQ-9 Modified for Teens

Name _____ Clinician _____

Medical Record or ID Number _____ Date _____

Instructions: How often have you been bothered by each of the following symptoms during the past two weeks?
For each symptom put an "X" in the box beneath the answer that best describes how you have been feeling.

	(0) Not At All	(1) Several Days	(2) More Than Half the Days	(3) Nearly Every Day
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself — or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading, or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				

10. In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes? Yes No

11. If you are experiencing any of the problems on this form, how **difficult** have these problems made it for you to do your work, take care of things at home or get along with other people?
 Not difficult at all Somewhat difficult Very difficult Extremely difficult

12. Has there been a time in the past month when you have had serious thoughts about ending your life? Yes No

13. Have you **ever**, in your **whole life**, tried to kill yourself or made a suicide attempt? Yes No

FOR OFFICE USE ONLY Score _____

Q. 12 and Q. 13 = Y or TS \geq 11

A Survey From Your Healthcare Provider – PSC-Y

Name		Date	ID		
Please mark under the heading that best fits you or circle Yes or No			Never 0	Sometimes 1	Often 2
-	1. Complain of aches or pains				
-	2. Spend more time alone				
-	3. Tire easily, little energy				
●	4. Fidgety, unable to sit still				
-	5. Have trouble with teacher				
-	6. Less interested in school				
●	7. Act as if driven by motor				
●	8. Daydream too much				
●	9. Distract easily				
-	10. Are afraid of new situations				
▲	11. Feel sad, unhappy				
-	12. Are irritable, angry				
▲	13. Feel hopeless				
●	14. Have trouble concentrating				
-	15. Less interested in friends				
■	16. Fight with other children				
-	17. Absent from school				
-	18. School grades dropping				
▲	19. Down on yourself				
-	20. Visit doctor with doctor finding nothing wrong				
-	21. Have trouble sleeping				
▲	22. Worry a lot				
-	23. Want to be with parent more than before				
-	24. Feel that you are bad				
-	25. Take unnecessary risks				
-	26. Get hurt frequently				
▲	27. Seem to be having less fun				
-	28. Act younger than children your age				
■	29. Do not listen to rules				
-	30. Do not show feelings				
■	31. Do not understand other people's feelings				
■	32. Tease others				
■	33. Blame others for your troubles				
■	34. Take things that do not belong to you				
■	35. Refuse to share				
◆	36. During the past three months, have you thought of killing yourself?			Yes	No
◆	37. Have you ever tried to kill yourself?			Yes	No

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- Plan for Follow-up Annual screening Return visit w/ PCP Referred to counselor
 Parent declined Already in treatment Referred to other professional

TS _____
Q 36 or Q 37=Y ◆ TS ≥ 30