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

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MENTAL HEALTH QUESTIONNAIRE

Maryland Healthy Kids Program

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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. 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
3. 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
4. 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
5. 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

Tuberculosis Risk Assessment: *(Starting at 1 month 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?	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

Anemia Screening (Starting at 11 years of age and annually thereafter)	Date ____	Date ____	Date ____	Date ____	Date ____	Date ____	Date ____
1. Does your 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. 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

(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

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)

STI/HIV Risk Assessment: *(11 years through 20 years)*	Date ___	Date ___	Date ___	Date ___	Date ___	Date ___	Date ___
1. 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
2. Have you ever been sexually molested or physically attacked?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
3. Have you ever been diagnosed with any sexually transmitted diseases?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
4. 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
5. 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
6. If sexually active, have you had more than one partner?	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N	Y / N
7. 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

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

Patient Name:______________________________ **Birth Date:** ______________

1. Which of these meals or snacks did you eat yesterday?
   (*Check all that apply*)
   - ☐ Breakfast
   - ☐ Lunch
   - ☐ Dinner or supper
   - ☐ Morning snack
   - ☐ Afternoon Snack
   - ☐ Evening/late-snack

2. Do you skip breakfast 3 or more times a week?
   ☐ Yes ☐ No
   Do you skip lunch 3 or more times a week?
   ☐ Yes ☐ No
   Do you skip dinner or supper 3 or more times a week?
   ☐ Yes ☐ No

3. Do you eat dinner or supper with your family 4 or more times a week?
   ☐ Yes ☐ No

4. Do you fix or buy the food for any of your family's meals?
   ☐ Yes ☐ No

5. Do you eat or take out a meal from a fast food restaurant 2 or more times a week?
   ☐ Yes ☐ No

6. Are you on special diet for medical reasons?
   ☐ Yes ☐ No

7. Are you a vegetarian?
   ☐ Yes ☐ No

8. Do you have any problems with your appetite, like not feeling hungry, or feeling hungry all the time?
   ☐ Yes ☐ No

9. Which of the following did you drink last week?(*Check all that apply*)
   - ☐ Tap or bottled water
   - ☐ Fitness water
   - ☐ Juice
   - ☐ Regular soft drinks
   - ☐ Diet soft drinks
   - ☐ Fruit-flavored drinks
   - ☐ Sport drinks
   - ☐ Energy drinks
   - ☐ Recovery drinks
   - ☐ Fat-free (skim) milk
   - ☐ Low-fat (1%) milk
   - ☐ Reduced-fat (2%) milk
   - ☐ Whole milk
   - ☐ Flavored milk (for example, chocolate, strawberry)
   - ☐ Coffee or tea
   - ☐ Beer, wine, or hard liquor

10. Which of these foods did you eat 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
- ☐ Pies
- ☐ Soft drinks
- ☐ Other fats and sweets: ……………..

11. Do you have a working stove, oven, and refrigerator where you live?
☐ Yes ☐ No

12. Were there any days last month when your family didn't have enough food to eat or enough money to buy food?
☐ Yes ☐ No

13. Are you concerned about your weight?
☐ Yes ☐ No

14. Are you on a diet now to lose weight or to maintain your weight?
☐ Yes ☐ No

15. In the past year, have you tried to lose weight or control your weight by vomiting, taking diet pill or laxatives, or not eating?
☐ Yes ☐ No

16. 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?………………………

17. Did you spend more than 2 hours per day watching television and DVDs or playing computer games?
☐ Yes ☐ No
If yes, how many hours per day?……………..

18. Does the family watch television during meals?
☐ Yes ☐ No

19. Do you take vitamin, mineral, herbal, or other dietary supplements (for example, protein powders)?
☐ Yes ☐ No

20. Do you smoke cigarettes or chew tobacco?
☐ Yes ☐ No

21. Do you ever use any of the following? *(Check all that apply)*
- ☐ Alcohol, beer, or wine
- ☐ Steroids (without a doctor's permission)
- ☐ Street drugs (marihuana, speed, crack, or heroin)